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Scaling Cost-Sharing to Wages: How Employers Can Reduce Health Spending and Provide Greater Economic Security

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ARTICLES

Scaling Cost-Sharing to Wages: How Employers Can Reduce Health Spending and Provide Greater Economic Security

Christopher T. Robertson *

ABSTRACT:

In the employer-sponsored insurance market that covers most Americans; many workers are “underinsured.” The evidence shows onerous out-of-pocket payments causing them to forgo needed care, miss work, and fall into bankruptcies and foreclosures. Nonetheless, many higher-paid workers are “overinsured”: the evidence shows that in this domain, surplus insurance stimulates spending and price inflation without improving health. Employers can solve these problems together by scaling cost-sharing to wages. This reform would make insurance better protect against risk and guarantee access to care, while maintaining or even reducing insurance premiums.

Yet, there are legal obstacles to scaled cost-sharing. The group-based nature of employer health insurance, reinforced by federal law, makes it difficult for scaling to be achieved through individual choices. The Affordable Care Act’s (ACA) “essential coverage” mandate also caps cost-sharing even for wealthy workers that need no such cap. Additionally, there is a tax distortion in favor of highly paid workers purchasing healthcare through insurance rather than out-of-pocket. These problems are all surmountable. In particular, the ACA has expanded the applicability of an unenforced employee-benefits rule that prohibits

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“discrimination” in favor of highly compensated workers. A novel analysis shows that this statute gives the Internal Revenue Service the authority to require scaling and to thereby eliminate the current inequities and inefficiencies caused by the tax distortion. The promise is smarter insurance for over 150 million Americans.

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INTRODUCTION AND EXECUTIVE SUMMARY

The Affordable Care Act (ACA) has primarily focused on expanding access to health insurance, but it is time to look more closely at whether insurance is achieving its core purposes: to protect individuals from risk and to ensure access to healthcare when needed.¹ Can health insurance better serve those purposes, and can it do so without wastefully stimulating healthcare spending?

This Article will focus on the employer-sponsored health insurance market, where most Americans are covered and will continue to be covered under the ACA.² Health insurance premiums are said to be a drag on corporate profits and global competitiveness.³ Still, much of the costs of health insurance premiums are passed on to workers as a substitute for wages.⁴ Thus, “the increasing cost of health care has resulted in relatively flat real wages for 30 years.”⁵

In the United States, cost-sharing has become the primary mechanism for reducing insurance expenditures and, by extension, maintaining affordable

1. See Allison K. Hoffman, *Three Models of Health Insurance: The Conceptual Pluralism of the Patient Protection and Affordable Care Act*, 159 U. PA. L. REV. 1873 (2010) (discussing health promotion, financial security, and brute luck theories). See generally D.M. Cutler & R. J. Zeckhauser, *The Anatomy of Health Insurance*, in 1 HANDBOOK OF HEALTH ECONOMICS 563 (A.J. Culyer & J.P. Newhouse eds., 2000) (arguing for health insurance as a protector of economic security). For a classic economic approach to insurance, see Milton Friedman & L. J. Savage, *The Utility Analysis of Choices Involving Risk*, 56 J. POL. ECON. 279, 295 (1948) (discussing risk and insurance in relation to income).

2. See 26 U.S.C.A. § 4980H (West 2014) (employer mandate under the ACA); CBO’s *February 2013 Estimate of the Effects of the Affordable Care Act on Health Insurance Coverage*, CBO (Feb. 2013), <http://www.cbo.gov/sites/default/files/cbofiles/attachments/43900-2013-02-ACA.pdf> (projecting that as a result of the ACA, by 2023 employers sponsored coverage for 167 million non-elderly people, out of 288 million total, or 58%). But see Suja A. Thomas & Peter Molk, *Employer Costs and Conflicts Under the Affordable Care Act*, 99 CORNELL L. REV. ONLINE 56 (2013) (discussing problems in the employer mandate).

3. See generally Toni Johnson, *Healthcare Costs and U.S. Competitiveness*, COUNCIL ON FOREIGN REL. (Mar. 2010), <http://www.cfr.org/competitiveness/healthcare-costs-us-competitiveness/p13325>.

4. See Katherine Swartz, *Revising Employers’ Role in Sponsoring and Financing Health Insurance/Medical Care*, in A FUTURE OF GOOD JOBS? AMERICA’S CHALLENGE IN THE GLOBAL ECONOMY 86 (Timothy J. Bartik & Susan N. Houseman eds., 2008) (“Depending on the circumstances, workers, companies, consumers, and company stockholders all pay varying shares of the costs.”).

5. Ezekiel J. Emanuel & Victor R. Fuchs, *Who Really Pays for Health Care? The Myth of “Shared Responsibility,”* 299 JAMA 1057, 1058 (2008). See also VICTOR FUCHS, WHO SHALL LIVE? HEALTH, ECONOMICS AND SOCIAL CHOICE 127–28 (1993) (“[T]he public must pay for care under any system of finance . . . the ultimate cost falls on families and individuals even when the payment mechanism makes it appear that the bills are being sent elsewhere.”); William M. Sage, *Should the Patient Conquer?*, 45 WAKE FOREST L. REV. 101, 103 (2010) (“We seem finally to have reached the point at which spending more on health care means denying our other material needs.”).

coverage.⁶ Cost-sharing involves patients making various out-of-pocket (OOP) payments (or “user fees”) including deductibles, copays, coinsurance, and reference prices.⁷

However, because cost-sharing exposure is in effect the absence of insurance for those expenses, cost-sharing can undermine the primary function of insurance. When cost-sharing exposure is too large, the beneficiary is no longer guaranteed access to the healthcare that she needs, or may only be able to secure access by reallocating from other necessities. This could trigger bankruptcy or home foreclosure. To protect the beneficiary against such risks, the insurance policy caps the annual out-of-pocket exposure: this “catastrophic limit” is the maximum exposure to uninsured risk, beyond which the individual enjoys full insurance.

Such a cap is anathema for cost control, however. Individuals rarely need extensive healthcare services. The vast majority of health spending is consumed by a few unpredictable people who account for tens of thousands of dollars of healthcare in a given year.⁸ Thus, the cap deprives the insurer of its primary cost-control mechanism at precisely the point where the expenditure decisions are most impactful on aggregate costs.

The two goals for a rational health insurance policy are thus in “inherent tension.”⁹ Too high a cap hinders risk protection. Too low a cap hinders cost-control.

A significant problem has been largely ignored in health insurance design, especially in the development of cost-sharing models. Namely, individuals have

6. See generally *Employer Health Benefits: 2012 Annual Survey*, KAISER FAM. FOUND. & HEALTH RES. & EDUC. TR. (2012) [hereinafter *Employer Health Benefits 2012*], <http://kaiserfamilyfoundation.files.wordpress.com/2013/03/8345-employer-health-benefits-annual-survey-full-report-0912.pdf> (showing the prevalence of this strategy). See also MARK A. HALL, MAKING MEDICAL SPENDING DECISIONS: THE LAW, ETHICS & ECONOMICS OF RATIONING MECHANISMS 3–6 (1997) (explaining that some form of rationing is inevitable); Clark C. Havighurst, *Prospective Self-Denial: Can Consumers Contract Today to Accept Health Care Rationing Tomorrow?*, 140 U. PA. L. REV. 1755, 1758 (1992) (same).

7. See *infra* Section I.A.

8. Cf. Steven B. Cohen & William Yu, *The Concentration and Persistence in the Level of Health Expenditures Over Time: Estimates for the U.S. Population, 2008–2009*, AGENCY FOR HEALTHCARE RESEARCH & QUALITY 1, (Statistical Brief #354, Jan. 2012), http://meps.ahrq.gov/data_files/publications/st354/stat354.pdf.

9. Katherine Swartz, *Cost-Sharing: Effects on Spending and Outcomes*, ROBERT WOOD JOHNSON FOUND. 1 (Res. Synthesis Rep. No. 20, Dec. 2010), http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2010/rwjf402103/subassets/rwjf402103_1. See also James C. Robinson, *Insurers' Strategies for Managing the Use and Cost of Biopharmaceuticals*, 25 HEALTH AFF. 1205, 1215 (2006) (“Benefit designs emphasizing consumer cost sharing are both too effective, pushing some patients to the brink of bankruptcy, and insufficiently effective, since a large fraction of total biopharmaceutical costs are incurred by patients who already have spent through their deductibles and annual payment limits.”).

radically different abilities to bear risk. For instance, those in the top quintile are paid five times more than those in the bottom quintile.¹⁰ And income is an accepted proxy for the ability to bear financial risk. Yet, within a given health plan, they all have the same cost-sharing burdens. Accordingly, the cap will be too high for some beneficiaries, making them “underinsured.”¹¹ The same cap will be too low for other beneficiaries, removing the price signal sooner than necessary and making them “overinsured.”¹² A one-size-fits-all approach sets a cost-sharing limit that is arbitrary for each individual. It is untethered to its risk-protection purpose.

As a few scholars and firms have begun to realize, the optimal insurance policy will instead be one that scales the cost-sharing burdens for each beneficiary to his or her ability to bear that uninsured risk.¹³ Scaled cost-sharing (SCS) is feasible in a world where employers pay wages and provide health insurance; the two data points need only be linked together. One imperfect but feasible mechanism for such tailoring would look like the following: instead of exposing all beneficiaries to the same fixed dollar amount of uninsured risk per year, the insurer would expose all beneficiaries to the same percent of their wages as the uninsured risk. For example, we could use as a baseline a common cost-sharing profile that includes a \$3,000 cost-sharing cap, and apply it to a median American worker with a \$50,000 income. This median worker with an average plan faces a 6% cost-sharing ratio. We could then apply that same 6% ratio across the board, scaling the absolute cost-sharing amount upwards and downwards with each person’s income. In this arrangement, each beneficiary gets roughly the protection from risk that she needs, while also continuing to have as much skin in the game as she can handle.

There are normative reasons for scaling health insurance risk to wages that track the general purposes of health insurance: fairness and access to needed care.¹⁴ The current mechanism of using unscaled cost-sharing thresholds is regressive in application. We would not tolerate this type of regressivity if the cost-sharing burdens were conceived as taxes. Nonetheless, in a time when employer-sponsored insurance coverage is mandated and subsidized by the federal government, such an analogy may be apt. More generally, proper implementation of SCS also blunts some of the most trenchant normative objections to cost-sharing, such as those levied by luck egalitarians.¹⁵ This Article will argue that ability-to-pay should be the overriding criterion for

10. See *infra* Figure 1.

11. See *infra* Section I.B.

12. See *infra* Section I.C.

13. See *infra* Part II.

14. See *infra* Section II.A.

15. See *infra* text accompanying note 102 (defining and discussing luck egalitarianism).

normative evaluation of health insurance mechanisms.

This is not a zero-sum reform. SCS should also appeal to rational employers who seek to maximize shareholder value.¹⁶ Since the distribution of American workers' incomes is concentrated in favor of the highly compensated, proportional income-scaling will also be asymmetric, adding four times more cost-sharing than it removes, thereby significantly reducing the aggregate burden of insurance premiums.¹⁷ SCS is also unique among "consumer-directed health insurance" reforms in that it targets high-cost healthcare, which accounts for the bulk of overall spending. Thus, SCS could significantly reduce insurance outlays in this second respect. Moreover, SCS promises to deliver better health outcomes and enhanced worker productivity for each dollar spent on health insurance.¹⁸ For these reasons, SCS may allow a greater bargaining surplus between workers and shareholders.

After conducting a normative and economic analysis of this reform, including a review of the scant precedents in scholarship, the market, and federal law, this Article investigates the question of why employers have not widely adopted wage-scaled cost-sharing. In particular, this Article engages in legal analysis to explore and solve four potential sources of market failure.

First, one might wonder why a choice-based system, in which workers would select their own cost-sharing profiles and pay insurance premiums accordingly, has not emerged. Car and home insurance often already operate in this fashion.¹⁹ The longstanding practice of employers subsidizing health insurance and the legal limits on individual-rating of premiums present obstacles to this approach. In this domain, choice also presents problems of adverse selection by allowing beneficiaries to exploit their private information, which undermines the risk-pooling function of insurance. More generally, a choice-based mechanism could be compromised by the severe cognitive limits that individuals face when making such complex decisions about risk. As a result, greater intervention by employers and regulators may be sensible in this domain; they could move toward scaling while holding constant the lack of choice that exists under the status quo. Nonetheless, as an intermediate step, employers could implement scaling as a default rule.

A second significant obstacle is that well-intentioned caps on cost-sharing in the ACA limit the potential application of SCS.²⁰ This is an unfortunate flaw in the ACA, but the executive and legislative branches have fixes at their disposal. Even without such reforms, employers have considerable discretion to use

16. See *infra* Section II.B.

17. See *infra* Table 1.

18. See *infra* Section II.C.

19. See *infra* Section III.A.

20. See *infra* Section III.B.

scaling beneath those statutory caps.

Third, there may be an agency problem. Managers responsible for designing the firm's insurance policy are paid more than the median worker, which may cause them to reject SCS even if it would improve profits for the shareholders.²¹ There is a related collective action problem in the market for talented workers. Employers are hesitant to be the first to impose higher cost-sharing burdens on their highest-paid workers, lest they lose them. Fundamentally, these problems are caused by the tax code, which creates a distortion in favor of health spending through insurance. This distortion is especially pronounced for high-paid workers.

Fourth, there may be misperceptions that current federal law prohibits this sort of "discrimination" by salary levels.²² This Article's analysis reveals that the law is actually permissive. Indeed, it obliges employers to use scaling in order to allow lower-paid workers to get the full benefit of their health insurance without hiding tax-free compensation for top workers in the form of unnecessary insurance. Thanks to an expansion of this unenforced rule in the ACA, the IRS now has a legal mechanism to counteract the distortion of the tax preference. It need only clarify its regulations to require scaled cost-sharing. Accordingly, congressional action is unnecessary for this landmark reform. IRS action alone could better substantiate health insurance's goals and reduce its distortive effects on consumption. Scaled cost-sharing is smarter insurance.

I. COST-SHARING AND ITS LIMITS

A. *Three Zones of Insurance*

As a patient's spending on healthcare grows month by month in any given year, she moves through three different "zones" of insurance, from no insurance, to partial insurance, and finally to full insurance. These stages correspond to different features of typical cost-sharing schemes.

- **Zone 1 – No Insurance:** An annual deductible gives the patient complete responsibility for the first health expenditures in a year. In other words, the patient has 100% skin in the game. In PPO plans (Preferred Provider Organizations, which cover most patients in the USA), three quarters of beneficiaries have deductibles, and the average annual deductible is less than \$1,000.²³ About one fifth of American workers are in "high

21. See *infra* Section III.C.

22. See *infra* Section III.D.

23. *Employer Health Benefits 2012*, *supra* note 6, at 2 (showing that 77% of PPO beneficiaries have deductibles). For the distribution between PPO (Preferred Provider Organization) plans versus HMOs (Health Maintenance Organization), POS (Point of Service), and HDHP (High Deductible Health Plan) plans, see *id.* at 4 exhibit E (showing 56% in PPOs).

deductible health plans with a savings option,” and in these plans the average deductible is a bit over \$2,000.²⁴ This sector has been growing quickly, more than doubling since 2009. Federal law prohibits high-deductible health plans (HDHPs) from using deductibles above about \$6,000 for individuals or \$12,000 for families, but few reach that level anyway.²⁵

- Zone 2 – Some Insurance: Next, there is a middle range in which patients have insurance, but must also share the burden of healthcare consumption through copays, coinsurance, or reference pricing. A copay is a flat fee paid at a doctor’s office, hospital, or pharmacy. For example, the average copay for a primary care visit is \$23 and \$118 for an ER visit.²⁶ Coinsurance is a percentage of the service charge (often about 18%) that the health plan demands that the patient reimburse.²⁷ Under a “reference price,” an insurer pays a fixed amount for a service and the beneficiary pays all charges above that fixed amount.²⁸
- Zone 3 – Full Insurance: Finally, there is a zone in which patients have no skin in the game. “Eighty-seven percent of covered workers have an out-of-pocket maximum for single coverage, but the actual dollar limits differ considerably.”²⁹ Most individual workers (59%) have cost-sharing burdens capped at some amount less than \$3,000 per year (or less than \$5,500 for family-coverage).³⁰ Only 2% of individually covered workers are exposed to more than \$6,000 in costs per year.³¹ Nonetheless, even plans that have identical out-of-pocket limits may vary considerably on how those limits are applied, making it difficult to generalize across plans.³²

24. *Id.* at 2. For the number in HDHPs, see *id.* at 4 exhibit E (showing 19%).

25. See *id.* at 127 exhibit 7-31 (showing HDHPs for individuals with only 3% at the level of \$6,000 or more, and 24% over \$5,000).

26. *Id.* at 3.

27. See *id.* at 121 exhibit 7-21 (showing the 18% figure).

28. See James C. Robinson & Timothy T. Brown, *Increases in Consumer Cost Sharing Redirect Patient Volumes and Reduce Hospital Prices for Orthopedic Surgery*, 32 HEALTH AFF. 1392 (2013) (utilizing a natural experiment to assess the impact of reference prices).

29. *Employer Health Benefits 2012*, *supra* note 6, at 4–5.

30. See *id.* at 127 exhibit 7-31 (last row, adding the first two items together: 32% for \$1,999 or less plus 27% for \$2000–\$2999). For the out-of-pocket (OOP) maximums for family coverage, see *id.* at 129 exhibit 7-33 (last row, adding the first three categories, yielding 51% having a maximum of \$5,499 or less).

31. *Id.*

32. See Karen Pollitz et al., *Coverage When It Counts: How Much Protection Does Health Insurance Offer and How Can Consumers Know?*, CENTER FOR AM. PROGRESS ACTION FUND, 6 (May 2009). <http://www.americanprogressaction.org/wp-content/uploads/issues/2009/05/pdf/CoverageWhenItCounts.pdf>. The authors surveyed ten insurance policies in Massachusetts and found that “annual out-of-pocket limits in many policies do not cap all forms of cost sharing.” In a comparison of two particular plans, the authors note that “[b]oth policies have an annual out-of-

Overall, in the typical employer-sponsored plan, the employees bear about 18% of the cost of healthcare at the point of consumption; the remaining 82% is borne by the insurer.³³ But for individual patients, the burden in a given year can be quite different, making an average figure misleading. Imagine Ms. Mildred Median, a patient in a plan with a \$1,000 deductible, an 18% coinsurance burden, and a \$3,000 cost-sharing maximum (the typical figures on each of these three modalities).³⁴ Suppose that this year, Ms. Median will spend tens of thousands of dollars on a heart stent or a chemo drug, or other high-cost care that, in the aggregate, accounts for most health spending in the United States.³⁵ After spending her \$1,000 deductible, Ms. Median will be exposed to up to \$2,000 more in costs (\$3,000 cap minus the \$1,000 deductible).³⁶ Given her 18% coinsurance rate, that \$2,000 will be consumed after the next \$11,111 in healthcare expenses.³⁷ Thus, Ms. Median has reached Zone 3, the range of full insurance with zero skin in the game, after consuming \$12,111 in health expenses, \$3,000 of which she paid out of pocket.

For Ms. Median, the cap is a good thing. If she also earns a median family income of about \$51,000, she has now consumed 6% of her income. Depending on her other obligations, and the amount she has put into savings, Ms. Median may not have been able to bear more risk. In this sense, the insurance is doing exactly what it was designed to do.

Even this median level of cost-sharing may be too much for middle-class Americans.³⁸ However, let us assume, *arguendo*, that current median levels of

pocket limit of \$5,000. Yet, the breast cancer patient would pay \$7,641 in cost sharing under Plan D and \$12,907 in cost sharing under Plan C.”

33. CHRIS PETERSON, CONG. RESEARCH SERV., R4049, SETTING AND VALUING HEALTH INSURANCE BENEFITS (2009) (showing that the typical employer sponsored PPO has an actuarial value of 80–84%).

34. See *supra* discussion accompanying notes 23–31.

35. See Cohen & Yu, *supra* note 8, at 1 (noting that “[i]n both 2008 and 2009, the top 5 percent of the population accounted for nearly 50 percent of health care expenditures” and that “those individuals ranked in the top 5 percent of the health care expenditure distribution in 2008 [had] a mean expenditure of \$35,829”).

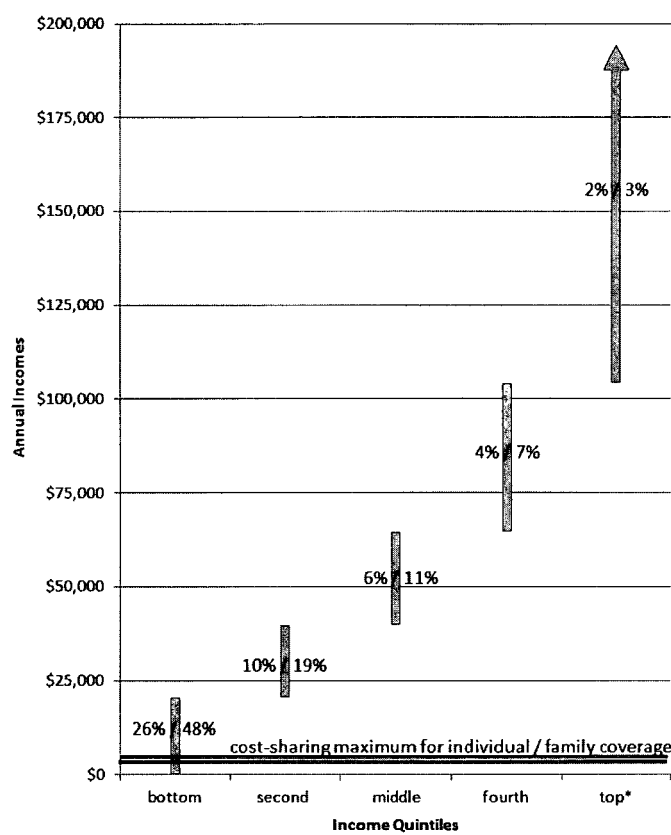
36. Most plans count deductible spending towards the OOP maximum, as I do here. See *Employer Health Benefits 2012*, *supra* note 6, at 126 exhibit 7.30 (showing that 15–36% of plans, depending on type, exclude spending on the deductible for the OOP maximum).

37. The 18% coinsurance rate, multiplied by \$11,111 yields \$2,000 more in OOP spending. When added to the \$1,000 deductible, the \$3,000 cap is reached.

38. See generally JACOB S. HACKER, THE GREAT RISK SHIFT: THE NEW ECONOMIC INSECURITY AND THE DECLINE OF THE AMERICAN DREAM 137–43 (2006) (discussing the economic insecurity that even middle class Americans face due to healthcare problems). If individuals are suffering from severe cognitive biases at the point of healthcare consumption, it is also possible that current cost-sharing levels may over-correct in their function of modifying behavior. See Abigail Moncrieff, *The Individual Mandate as Healthcare Regulation: What the Obama Administration Should Have Said in NFIB v. Sebelius*, 39 AM. J.L. & MED. 539 (2013) (arguing that insurance solves a problem of hyperbolic discounting and optimism).

cost-sharing are appropriate, so that Ms. Median provides a point of reference. With that point of reference, we can understand the twin problems of underinsurance and overinsurance.

FIGURE 1: INCOME QUINTILES FOR U.S., LISTING TYPICAL ANNUAL HEALTH INSURANCE COST-SHARING MAXIMUMS FOR INDIVIDUALS/FAMILIES AS A PERCENTAGE OF INCOME³⁹



39. Author's calculations are based on U.S. Census Bureau data for 2012 incomes. Carmen DeNavas-Walt et al., *Income, Poverty, and Health Insurance Coverage in the United States: 2012: Current Population Reports*, U.S. CENSUS BUREAU (Sept. 2013), <http://www.census.gov/prod/2013pubs/p60-245.pdf>. The percentages show the cost-sharing maximums (\$3,000 for individual coverage, \$5,000 for family coverage) as a proportion of income for the mean household in each quintile. See *Employer Health Benefits 2012*, *supra* note 6. The top 5% of incomes are visually censored. This graphic is for illustrative purposes. The actual cost-sharing maximum applicable to individuals varies depending on employers and particular plans, and the distribution of incomes within a particular employer-based plan is likely to be narrower than shown here.

B. Underinsurance

Even if manageable for Ms. Median, that same \$3,000 in health expenses in a single year could be devastating for individuals in the lower quintiles of income. As shown in the Census Bureau data plotted in Figure 1, above, those in the bottom quintile earn up to about \$20,000, less than half of Ms. Median's salary.⁴⁰ For workers in the middle of that quintile who do not turn to Medicaid or the health insurance exchanges, a \$3,000 outlay would be 26% of income.⁴¹ Even in the next quintile, which may be more typical of the lower-paid but insured individuals in Ms. Median's workplace, individuals would have to spend one of every ten dollars (10% of income) on copays and deductibles. This would be on top of the taxes and health insurance premiums already paid and the other expenses that come with illness.⁴² If it is coverage for a whole family getting by on that single income, then the maximum OOP exposure is 19% of income. Even worse, at the time of a health crisis the family income may actually go down, due to the worker's own incapacity or the worker's need to care for others in the household who are severely ill.

The individuals in these lower quintiles are likely "underinsured." In other words, the cost-sharing burdens are so onerous that they undermine the functions of insurance: to guarantee access to care and to protect against devastating financial risk.⁴³ Determining who precisely qualifies as underinsured raises a difficult line-drawing problem.⁴⁴ But that analytical problem does not make the practical reality disappear. As one 51-year old mother of two explained, "We're all one broken leg, one bad fall, or one case of pneumonia away from the house of cards completely falling down."⁴⁵

There is an expansive literature on the relationship between medical problems and financial distress.⁴⁶ Even among Americans who were insured all

40. DeNavas-Walt et al., *supra* note 39, at 9. A similar range of wages is found within firms.

41. This article is focusing on employer-sponsored health insurance, but Medicaid also covers some individuals with very low incomes. See *infra* notes 129–131 and accompanying text.

42. See Patricia Ketsche et al., *Lower-Income Families Pay a Higher Share of Income Toward National Health Care Spending than Higher-Income Families Do*, 30 HEALTH AFF. 1637, 1640 (2011) (showing that Americans in the bottom quintile of income spend, on average, about 10.2% of their income on healthcare out of pocket, while those at the top quintile of income spend only 0.9%, even though they consume more healthcare when they get sick).

43. See Cathy Schoen et al., *How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007*, 27 HEALTH AFF. w298 (2008).

44. However, workable definitions are available. See, e.g., Rashid Bashshur et al., *Defining Underinsurance: A Conceptual Framework for Policy and Empirical Analysis*, 50 MED. CARE REV. 199 (1993).

45. Peter J. Cunningham, Carolyn Miller & Alwn Cassil, *Living on the Edge: Health Care Expenses Strain Family Budgets*, CENTER FOR STUDYING HEALTH SYS. CHANGE (Res. Brief No. 10, (Dec. 2008).

46. See e.g., Alison A. Galbraith et al., *Nearly Half of Families in High-Deductible Health*

year, one in seven reported spending over 10% of their income on out-of-pocket medical expenses. Moreover, many insured individuals report difficulty paying medical bills, changing their way of life to pay medical bills, or being dunned by collection agencies for medical bills.⁴⁷ A national survey and review of court records found that 62% of bankruptcies had medical causes, including but not limited to out-of-pocket spending, and that three quarters of those filers had medical insurance at the start of their illness.⁴⁸ Similarly, millions of home foreclosures have been attributed to medical causes, even for those with health insurance.⁴⁹ These bankruptcies and foreclosures impose externalities on creditors and neighbors.

This body of research has been controversial, with some scholars questioning the size of the problem. Some have also characterized causality determinations as problematic since so many factors may contribute to financial distress.⁵⁰ Nonetheless, that the risk of financial disaster is exacerbated when exposure to medical costs is out of proportion to a person's ability to pay those costs rests on firm analytical footing.

Such a disparity between costs and ability to pay also distorts healthcare consumption decisions. It is worth remembering that cost-sharing is simply

Plans Whose Members Have Chronic Conditions Face Substantial Financial Burden, 30 HEALTH AFF. 322, 327 (2011) (finding that "lower income was significantly associated with greater financial burden" due to cost-sharing).

47. Schoen et al., *supra* note 43, at w301 exhibit 1 (13.5% paid over 10% of income in 2007); *id.* at w304 exhibit 4 (45% of underinsured and 21% of otherwise insured individuals had one of the listed problems with medical bills).

48. See, e.g., David U. Himmelstein et al. *Medical Bankruptcy in the United States, 2007: Results of a National Study*, 122 AM. J. MED., 741, 744–45 (2009); see also Tal Gross & Matthew J. Notowidigdo, *Health Insurance and the Consumer Bankruptcy Decision: Evidence from Expansions of Medicaid*, 95 J. PUB. ECON. 767 (2011) (finding through a quasi-experimental study that out-of-pocket medical costs roughly account for 26% of personal bankruptcies among low-income households).

49. Christopher Tarver Robertson et al., *Get Sick, Get Out: The Medical Causes of Home Foreclosures*, 18 HEALTH MATRIX 65, 90–94 (2008) (finding that more than half of foreclosures had medical causes; respondents in foreclosure who enjoyed health insurance paid an average of \$5,100 in out-of-pocket medical bills in the recent two years). See also Craig Pollack, *A Case-Control Study of Home Foreclosure, Health Conditions, and Health Care Utilization*, 88 J. URB. HEALTH 469 (2011) (finding an association between medical utilization and foreclosure, while finding insurance status to be comparable across cases and controls).

50. See Robertson, *supra* note 49, at 68, 97 (describing a "perfect storm" of factors conspiring to induce medical foreclosures); Edward R. Morrison et al., *Health and Financial Fragility: Evidence from Car Crashes and Consumer Bankruptcy* (Univ. Chi. Coase-Sandor Inst. for Law & Econ., Working Paper No. 655, 2d series, Oct. 2013), http://chicagounbound.uchicago.edu/cgi/viewcontent.cgi?article=1657&context=law_and_economics (reviewing the literature and performing a differences-in-differences analyses comparing car accidents, medical bills, and bankruptcy filings in one state, and finding that the bankruptcy filing rate for those admitted to the hospital after an accident is 45% higher than those not admitted, but using regression controls to suggest that the causes are jointly determined by background factors).

uninsured risk, and therefore, when that amount is onerous, underinsured individuals behave just like uninsured individuals.⁵¹ Underinsured individuals decline even high-value care.⁵² One recent study of individuals in high-deductible health plans focused on emergency room visits, and distinguished between appropriate utilization for high-severity incidents and inappropriate utilization for low-severity incidents. The study found that the HDHP caused poorer beneficiaries to dramatically reduce the amount of high-severity emergency care they consumed.⁵³ Similarly, after acute myocardial infarction, it is very important for individuals to get follow-up healthcare and medication. One survey of patients with this condition found that one in seven experienced financial barriers to getting that care, and over two thirds of those enjoyed health insurance.⁵⁴ More generally, if cost-sharing causes individuals to decline high-value healthcare, it undermines the price signal of a competitive market by failing to properly reward high-impact innovations.⁵⁵

Health outcomes also suffer when cost-sharing burdens leave individuals underinsured. There are many observational studies of this phenomenon, but here too it is difficult to determine causation. There are many observable and unobservable differences between those who have adequate versus inadequate insurance.⁵⁶ The gold-standard investigation of this phenomenon is the RAND

51. See Michael D. Kogan et al., *Underinsurance Among Children in the United States*, 363 NEJM 841, 844, 847 (2010) (finding that 24% of children with continuous private insurance were underinsured, and that “the group of children who were underinsured did not differ significantly from the group of children who were never insured with respect to delayed or forgone care, lack of a medical home, [and] difficulty obtaining referrals”).

52. See M. Gregg Bloche, *Consumer-Directed Health Care and the Disadvantaged*, 26 HEALTH AFF. 1315, 1318 (2007); Steffie Woolhandler & David U. Himmelstein, *Consumer Directed Healthcare: Except for the Healthy and Wealthy It's Unwise*, 22 J. GEN. INTERNAL MED. 879 (2006). The RAND Health Insurance Experiment found that increased cost-sharing burdens caused individuals to decline high-value and low-value healthcare alike. See JOSEPH P. NEWHOUSE & INS. EXPERIMENT GRP., *FREE FOR ALL?: LESSONS FROM THE RAND HEALTH INSURANCE EXPERIMENT* 339 (1993).

53. J. Frank Wharam et al., *Low-Socioeconomic-Status Enrollees In High-Deductible Plans Reduced High-Severity Emergency Care*, 32 HEALTH AFF. 1398 (2013).

54. Ali R. Rahimi et al., *Financial Barriers to Health Care and Outcomes After Acute Myocardial Infarction*, 297 JAMA 1063 (2007).

55. See Darius Lakdawalla & Neeraj Sood, *Insurance and Innovation in Health Care Markets* (Nat'l Bureau of Econ. Research, Working Paper No. 11602, 2005) (arguing on certain idealized assumptions that universal health insurance that guarantees access provides optimal incentives to patent-holders).

56. See e.g., Donald P. Oswald et al., *Underinsurance and Key Health Outcomes for Children with Special Health Care Needs*, 119 PEDIATRICS e341 (2007) (finding that “children with special health care needs who were underinsured had significantly poorer outcomes than did children who were adequately insured”); Rahmi, *supra* note 54 (finding that financial barriers to care were associated with worse recovery after acute myocardial infarction, more angina, poorer quality of life, and higher risk of rehospitalization).

Health Insurance Experiment (HIE), which randomly assigned individuals to health plans with different levels of cost-sharing and monitored their health spending and health outcomes for three years.⁵⁷ While cost-sharing did not have adverse effects on median and upper-income people, poorer individuals with chronic illnesses experienced worse health outcomes due to cost-sharing.⁵⁸ Indeed, there have been many subsequent studies in the intervening decades, and “[t]he better studies reinforce the HIE findings that low-income people in poor health are more likely to suffer adverse health outcomes, such as increased rates of emergency department (ED) use, hospitalizations, admission to nursing homes, and death, when increased cost-sharing causes them to reduce their use of health care.”⁵⁹

C. Overinsurance

Paracelsus said that the difference between a poison and a drug is the dosage. The right dose is the one that achieves the purposes of securing a health outcome while minimizing the adverse side effects. The prior section showed how too little insurance, which is to say too much cost-sharing, can undermine the purposes of protecting against risk and guaranteeing access to care. But there is also a problem of “overinsurance.” Insurance can also have the opposite side effect of stimulating consumption, even among those who could afford to consume without insurance.⁶⁰

Economists call this side effect “moral hazard.”⁶¹ Although the term is

57. NEWHOUSE & INS. EXPERIMENT GRP., *supra* note 52.

58. *Id.*

59. Swartz, *supra* note 9, at 12; see also R. Scott Braithwaite & Allison B. Rosen, *Linking Cost Sharing to Value: An Unrivalled Yet Unrealized Public Health Opportunity*, 146 ANNALS INTERNAL MED. 602, 603 (2007) (reviewing the literature showing adverse effects of cost-sharing on indigent individuals); Dahlia K. Remler & Jessica Greene, *Cost-Sharing: A Blunt Instrument*, 30 ANN. REV. PUB. HEALTH 293 (2009) (also reviewing the literature).

60. This meaning of “overinsurance” is distinct from the casualty insurance context, where the term refers to “insurance that exceeds in amount the actual cash value of the property insured.” *Overinsurance*, MERRIAM-WEBSTER, <http://www.merriam-webster.com/dictionary/overinsurance> (last visited Apr. 9, 2014).

61. See JOHN A. NYMAN, *THE THEORY OF DEMAND FOR HEALTH INSURANCE* 144–51 (2003); see also Mark V. Pauly, *The Economics of Moral Hazard: Comment*, 58 AM. ECON. REV. 531, 531 (1968) (criticizing the understanding of moral hazard as an individual moral failing as opposed to rational economic behavior in response to lower cost); Mark V. Pauly, *Adverse Selection and Moral Hazard*, in *INCENTIVES AND CHOICE IN HEALTH CARE* 107 (Frank A. Sloan & Hirschel Kasper eds., 2008) (distinguishing the moral hazard problem from the fact that health insurance can also expand access, solving a wealth effect); Deborah Stone, *Behind the Jargon: Moral Hazard*, 36 J. HEALTH POL. POL’Y & L. 887–91 (2011) (reviewing the literature on the way this term has been used and abused). It is also possible that insurance has a second behavioral function that causes individuals to make riskier lifestyle choices, which is sometimes referred to as “ex ante” moral hazard. See Anderson E. Stanciole, *Health Insurance and Lifestyle Choices: Identifying Ex Ante*

loaded, the economics are simple. If one group of persons is offered a product for free, and another group is offered a product for some affordable cost greater than zero, the latter group will consume less, all other things being equal. Full insurance (Zone 3) makes things free at the point of consumption, eliminating the possibility of making any cost-benefit tradeoffs. When costs are completely externalized to an insurer, individuals make purchases whose benefits are outweighed by the costs, which reduces social welfare.

Such purchases also disrupt the price signal that is essential to a well-functioning market. If patients have no concern for the tradeoff between price and value, producers (e.g., pharmaceutical companies) and providers (e.g., hospitals) will make goods and services with higher prices and lower value than they otherwise would.⁶² Rather than manufacturers investing in developing products that reduce costs and deliver more value to consumers, they may instead rationally invest in marketing existing products.⁶³ Indeed, this seems to be happening.⁶⁴

On the other hand, cost-sharing is designed to reintroduce some price sensitivity. In this way, a cost-sharing burden can reduce the number of treatments consumed or change which treatments are consumed.⁶⁵ It may change behavior in this way by causing the patient to consider “whether a purchase is worth its price” (or at least a fraction thereof) and sometimes say no.⁶⁶

When individuals exceed their cap on cost-sharing in Zone 2 and move into full insurance in Zone 3, this function is stymied.⁶⁷ To determine whether someone is overinsured, then, is to ask whether the cap is lower than necessary to achieve the purposes of health insurance. If it is lower than necessary, then

Moral Hazard in the US Market, 33 GENEVA PAPERS ON RISK & INS. 627, 644 (2008).

62. See, e.g., Robinson & Brown, *supra* note 28.

63. See REGINA E. HERZLINGER, MARKET-DRIVEN HEALTH CARE: WHO WINS, WHO LOSES IN THE TRANSFORMATION OF AMERICA’S LARGEST SERVICE INDUSTRY 84 (1999); Einer Elhauge, *The Limited Regulatory Potential of Medical Technology Assessment*, 82 VA. L. REV. 1525 (1996) (discussing the distorted incentives in healthcare production).

64. See Marc-Andre Gagnon & Joel Lexchin, *The Cost of Pushing Pills: A New Estimate of Pharmaceutical Promotion Expenditures in the United States*, 5 PLOS MED. 29, 32 (2008) (discussing a PhRMA press release and concluding that “pharmaceutical companies spend almost twice as much on promotion as they do on R&D”).

65. See *Kennedy v. Conn. Gen. Life Ins. Co.*, 924 F.2d 698 (7th Cir. 1991) (explaining the behavior-modification function, and upholding an insurer’s refusal to pay a provider of medical services that waived a copayment).

66. Mark A. Hall & Carl E. Schneider, *Patients as Consumers: Courts, Contracts, and the New Medical Marketplace*, 106 MICH. L. REV. 643, 659 (2008); see also Michael Chernenow et al., *Value-Based Insurance Design*, 26 HEALTH AFF. w195, w195–96 (2007) (describing this as “standard economic theory”).

67. Timothy Stoltzfus Jost, *Our Broken Health Care System and How to Fix It: An Essay on Health Law and Policy*, 41 WAKE FOREST L. REV. 537, 587 (2006) (“Once consumers reach the limits of the deductible, they have little reason to limit their consumption of health care . . .”).

insurance's side effect of demand stimulation is gratuitous; it is a cost without benefit.

For individuals in the top quintile of income, which starts at over \$100,000 per year and ranges to the hundreds of millions (so high that it extends well beyond the scale of Figure 1), the common \$3,000 worst-case scenario for cost-sharing would amount to only one out of every \$50 dollars they earn (2%). These individuals are likely overinsured. A \$4,000 cost-sharing exposure, or even a \$12,000 exposure, might not present an unbearable risk or undermine their access to healthcare. Many of those in the top two quintiles, representing 40% of workers, may be overinsured.

Here too, there are line-drawing and identification problems. Conceptually, one way to test for the existence of overinsurance is to remove some marginal insurance and see what happens. If the beneficiary consumes less healthcare but her health does not suffer, then the prior level of insurance may have been too large.

For median and higher-income beneficiaries, the HIE found that full health insurance stimulated spending compared to experimental conditions with bearable but substantial cost-sharing.⁶⁸ The effect was large: in experimental conditions with nearly full insurance—i.e., people that are always in Zone 3, like those that have exceeded their caps in any policy—the health expenses were 50% greater than in plans with large but bearable deductibles. With four experimental conditions, ranging from 0% insurance to 95% insurance, a dose-response relationship appeared. Lower cost-sharing led to more spending, even though the overall exposure to risk was capped at 10% of income or \$1,000.

Notably, the HIE's observed reduction of consumption had no detectable adverse impact on the health outcomes of the median and higher-income beneficiaries.⁶⁹ This finding suggests that they were overinsured prior to the experiment. Given the difficulties that individuals have in discerning the difference between high-value and low-value healthcare, and the lack of price transparency in the healthcare market, it is perhaps surprising that cost-sharing works at all.⁷⁰ Nonetheless, recent empirical studies have yielded similar findings

68. See generally NEWHOUSE & INS. EXPERIMENT GRP., *supra* note 52.

69. *Id.* Similarly, a recent randomized experiment assigned one group to receive Medicaid benefits compared to a control group that did not and “showed that Medicaid coverage generated no significant improvements in measured physical health outcomes in the first 2 years, but it did increase the use of health services.” Katherine Baicker et al., *The Oregon Experiment—Effects of Medicaid on Clinical Outcomes*, 368 NEJM 1713, 1713 (2013). Medicaid coverage did “raise rates of diabetes detection and management, lower rates of depression, and reduce financial strain.” *Id.*

70. See Uwe E. Reinhardt, *The Pricing of U.S. Hospital Services: Chaos Behind a Veil of Secrecy*, 25 HEALTH AFF. 57 (2006) (discussing the problem of price transparency); Peter A. Ubel, Amy P. Abernethy & S. Yousuf Zafar, *Full Disclosure—Out-of-Pocket Costs as Side Effects*, 369 NEJM 1484 (2013) (arguing that physicians have a duty to provide such price information to

to the HIE. They show that insurance stimulates spending and that cost-sharing reduces that effect, with little or no adverse impact documented for high-income individuals.⁷¹

It is possible for cost-sharing to reduce healthcare costs without undermining health because there are many procedures that have very high costs and little or no proven benefit.⁷² Some healthcare consumption is actually counterproductive.⁷³ According to a comprehensive review of the relevant literature, “less than half of all medical care is based on or supported by adequate evidence about its effectiveness.”⁷⁴ Scholars calculate that “\$910 billion per year, or 34%” of U.S. health spending is waste.⁷⁵

Examples of low-value but expensive healthcare include prophylactic heart stent surgeries (which cost about seven billion dollars a year but have not been

patients, and discussing state legal mandates for price transparency).

71. See, e.g., Robinson & Brown, *supra* note 28, at 1392 (showing reductions in consumption with cost-sharing); Marika Cabral & Neale Mahoney, *Externalities and Taxation of Supplemental Insurance: A Study of Medicare and Medigap* 3 (Nat’l Bureau of Econ. Research, Working Paper No. 19787, Jan. 2014) (showing by regression discontinuity analysis that Medigap policies offset cost-sharing burdens in Medicare and increase program spending by 22%). See generally JONATHAN GRUBER, *THE ROLE OF CONSUMER COPAYMENTS FOR HEALTH CARE: LESSONS FROM THE RAND HEALTH INSURANCE EXPERIMENT AND BEYOND* 10 (2006) (“In summary, more recent work in a wide variety of settings and for a wide variety of subpopulations has confirmed the main conclusion of the HIE: higher patient co-payments reduced medical utilization.”).

72. See generally Christopher T. Robertson, *A Presumption Against Expensive Healthcare Consumption*, 49 TULSA L. REV. (forthcoming 2014). One might wonder why physicians even offer such high-cost low-value procedures. See Christopher Robertson, Susannah Rose & Aaron Kesselheim, *Effect of Financial Relationships on the Behaviors of Health Care Professionals: A Review of the Evidence*, 40 J.L. MED. & ETHICS 452, 463 (2012) (calling for greater regulation of physicians’ financial incentives and relationships with industry); Stone, *supra* note 61, at 891 (suggesting that physicians rather than patients are the problem).

73. See Bernard Black et al., *The Impact of Health Insurance on Near-Elderly Health and Mortality* 24 (Northwestern Law & Econ. Res. Paper No. 12-09, Nov. 2013) (“Insured women with health insurance were more likely to receive hormone-replacement therapy, which in hindsight raised breast cancer rates without reducing heart disease rates. Insured men are more likely to receive prostate cancer screening and follow-up testing and treatment, with no overall benefit; the testing alone carries substantial mortality risk from infection. People with health insurance are more likely to receive CT scans without strong clinical indication; the radiation exposure then predicts higher cancer rates some years hence.”).

74. *Research on the Comparative Effectiveness of Medical Treatments: Issues and Options for an Expanded Federal Role*, CBO 11 (Dec. 2007), <http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/88xx/doc8891/12-18-comparativeeffectiveness.pdf>. A recent review of every article published in the *New England Journal of Medicine* for a decade found that when randomized trials were utilized to test the efficacy of commonly used medical procedures, they failed more often than passed. Vinay Prasad et al., *A Decade of Reversal: An Analysis of 146 Contradicted Medical Practices*, 88 MAYO CLINIC PROC. 790, 792 (2013).

75. Donald M. Berwick & Andrew D. Hackbarth, *Eliminating Waste in US Health Care*, 307 JAMA 1513, 1515 (2012); see also Barry R. Furrow, *Cost Control and the Affordable Care Act: CRAMPing Our Health Care Appetite*, 13 NEV. L.J. 822, 836–43 (2013) (reviewing this literature).

proven to be more effective than a safer and cheaper regimen of drugs) and off-label use of patented chemotherapy drugs (which have not been proven to be more effective than standard, generic drugs, and also account for billions of dollars of health spending).⁷⁶ These patients have time to consider cheaper standard-of-care regimens, and cost-sharing may be worthwhile if it nudges them in that direction.

The foregoing examples are useful to see that the value of healthcare consumption varies widely, but it bears emphasis that this conclusion does not depend on any showing that some particular health spending is good and other health spending is bad. Nor does it depend on the proposition that cost-sharing will make patients aware of this difference. Instead, this Article is agnostic about which and how much healthcare any individual should consume. The point here is just that surplus insurance distorts those decisions when the degree of coverage is unnecessary to serve its risk-protection and access-guarantee purposes. In Section II.A, the question will become normative: whether lower-paid workers should help pay for such distortive insurance, and whether it should be subsidized through tax policy.

Further, wasteful healthcare spending arises across the income spectrum, and the presence of health insurance exacerbates that problem because it eliminates the price signal for all workers.⁷⁷ The point here is simply that, for some workers, health insurance stimulates wasteful consumption without offsetting benefits for access and risk-protection. A lower amount of insurance could achieve its purposes just as well.

II. SCALED COST-SHARING (SCS)

Policymakers and insurance designers have been in a tug-of-war over whether to expand or contract health insurance.⁷⁸ Some have pointed to the underinsurance problem and clamored for reductions in or even the elimination of cost-sharing.⁷⁹ Meanwhile, the market, with nudges from some policymakers,

76. See Christopher Robertson, *The Split Benefit: The Painless Way to Put Skin Back in the Health Care Game*, 98 CORNELL L. REV. 921, 928–30 (2013) (discussing these two examples and citing sources from the medical literature).

77. See Steven B. Cohen & Namrata Uberoi, *Differentials in the Concentration in the Level of Health Expenditures Across Population Subgroups in the U.S., 2010*, AGENCY FOR HEALTHCARE RESEARCH & QUALITY 9 fig.7 (Statistical Brief #421 Jan. 2012), http://meps.ahrq.gov/mepsweb/data_files/publications/st421/stat421.pdf (showing similar distributions of high-spenders and low-spenders within each income quintile).

78. See Stone, *supra* note 61 (reviewing this literature).

79. See CAM DONALDSON, CREDIT CRUNCH HEALTH CARE 20, 26 (2011) (“User charges are an idea that is intellectually dead, but keeps coming back to threaten our publicly funded health care systems, and have thus been classed by leading health economists in Canada as a policy zombie. Occasionally, the zombie has to be slain It is wrong, unfair and ineffective to try to limit

has been moving towards greater cost-sharing, putatively to address “moral hazard.”⁸⁰ Each of these moves solves one side of the problem, but only by exacerbating the other. The more elegant solution comes from recognizing that, although overinsurance and underinsurance are both real problems, they affect two different populations. To address both sides of the problem, we need to tailor cost-sharing burdens to each beneficiary’s ability to pay.

This Article develops the proposal to scale the maximum out-of-pocket exposure (the Zone 3 threshold), and suggests that ability to pay should be approximated by the worker’s salary, as it is readily knowable by the employer, who pays those wages.⁸¹ Administrative costs may thus be minimized, since the data is already in the employer’s hands. An employer would only need to multiply the wages by a simple ratio (e.g., 6%) in order to calculate a new cap on overall cost-sharing. It may be tempting to interrogate workers’ ability to pay more precisely, but such efforts could become burdensome and divisive, while providing little additional accuracy compared to the large improvement gained as we move from no-scaling to income-scaling.⁸² Nonetheless, the employer should consider whether additional reliable information can be gathered at low cost, such as a certification by the employee as to whether his or her spouse earns significantly more income.⁸³

consumer and patient access through user fees”); MICHAEL J. GRAETZ & JERRY L. MASHAW, *TRUE SECURITY* 171 (1999) (discussing the risk of medical crises reducing income below a “decent” level and causing an “unacceptably steep decline in living standards”).

80. See generally Robinson, *supra* note 9 (discussing the market and policy trend towards greater cost-sharing).

81. An employer could also use the wages paid as a rebuttable presumption, and allow workers to submit contrary evidence. Generally, however, assuming that the employer is not going to also modify the premiums paid by workers to account for different cost-sharing levels, see *infra* Section III.B, then the workers will uniformly be motivated to request downward adjustments for cost-sharing, creating a skew.

82. See Katherine Swartz, Expert Reflection, *Easier Said than Done*, 36 J. HEALTH POL. POL’Y & L. 855, 855, 857 (2011) (focusing on premiums: “[I]t is difficult to judge people’s ability to afford a necessity like health insurance on the basis of simple factors such as income, age, number and age of family members, and their health status [along with] . . . ‘deserving’ exceptions I grudgingly began to realize that a simple percent-of-income rule was more practical and avoided moral debates that were sure to arise”); see also, Carla Saenz, *What is Affordable Health Insurance? The Reasonable Tradeoff Account of Affordability*, 19 KENNEDY INST. ETHICS J. 401 (2009) (proposing “the reasonable tradeoff account [where] one does not have to sacrifice other benefit(s) that are comparable in importance to the benefits of health coverage”). See generally Didem M. Bernard et al., *Wealth, Income, and the Affordability of Health Insurance*, 28 HEALTH AFF. 887 (2009) (discussing correlations between wealth and income).

83. Many firms already require employees to make a similar certification about whether the spouse is eligible for health insurance from another source. See e.g., Spouse/Partner Coverage Certification, MIAMI U., <http://www.units.muohio.edu/humanresources/documents/formslibrary/benefitswellness/SpouseCoverageCertification.pdf> (last visited Apr. 19, 2014). Note that part of the ACA seems to require firms to consider each employee’s household income, to determine whether its required worker’s contribution to insurance premiums complies with law, so the

A. Normative Considerations

This Section examines normative considerations around scaling. First, it considers whether scaling has a mandate from justice, and whether it is useful to draw on terms commonly used to evaluate taxation schemes. Next, it considers how ability to pay interacts with desert and value as criteria for normative evaluation of healthcare burdens.

A complete normative argument for scaling of cost-sharing burdens would require stipulation of a foundational theory of justice, but the appeal of SCS is not peculiar to any one such theory.⁸⁴ For instance, Norman Daniels offers a theory of “health justice,” which draws from John Rawls, focusing on equality of opportunity.⁸⁵ The application is straightforward. As shown above, those in the lower wage ranges are not getting the benefit of health insurance when their cost-sharing burdens are so high that they lack access to care and must make tragic choices on the verge of bankruptcy and foreclosure.⁸⁶ While other insured individuals enjoy access to that same care and do not face the tragic choices, we have failed to achieve the normative goal that is equality of opportunity.⁸⁷ Alternatively, perhaps we have failed to achieve the “decent minimum” that is required under many conceptions of justice.⁸⁸

These rationales track the more general arguments for ensuring access to needed care and protection against risk.⁸⁹ It is hard to imagine a theory of justice that would require universal health insurance, but would also countenance such an ineffective and unfair version of it.⁹⁰

information costs may already be sunk for that other statutory purpose. 26 U.S.C.A. § 36B(c)(2)(C)(i)(II) (West 2014).

84. For a more comprehensive discussion of the possible normative starting points, see William W. Fisher & Talha Syed, *Global Justice in Healthcare: Developing Drugs for the Developing World*, 40 U.C. DAVIS L. REV. 581, 602–47 (2007).

85. See generally NORMAN DANIELS, *JUST HEALTH: MEETING HEALTH NEEDS FAIRLY* (2008).

86. See *supra* note 38 and accompanying text. Note that these studies of medical bankruptcies and medical foreclosures have found a significant incidence even among those with health insurance, due to large levels of out-of-pocket medical spending.

87. See Brendan Saloner & Norman Daniels, *The Ethics of the Affordability of Health Insurance*, 36 J. HEALTH POL. POL'Y & L. 815, 815 (2011) (discussing the onerous cost-sharing exposure that remains even under the ACA, in light of Daniels's theory of health justice).

88. See generally Allen E. Buchanan, *The Right to a Decent Minimum of Health Care*, 13 PHIL. & PUB. AFF. 55 (1984).

89. See Einer Elhauge, *Allocating Health Care Morally*, 82 CALIF. L. REV. 1449, 1455, 1480 (1994) (arguing for a right to access the level of care enjoyed by the middle class: “An individual’s ability to pay should indeed be irrelevant to determining that individual’s access to the minimum of adequate care.”); see also Allison Hoffman, *Oil and Water: Mixing Individual Mandates, Fragmented Markets, and Health Reform*, 36 AM. J.L. & MED. 7, 10–12 (2009); Sharona Hoffman, *Unmanaged Care: Towards Moral Fairness in Health Coverage*, 78 IND. L.J. 659, 668 (2003).

90. John V. Jacobi, *Consumer-Directed Health Care and the Chronically Ill*, 38 U. MICH. J.L. REFORM 531, 581 (2005). (arguing that “[i]t is difficult to describe a person as having ‘health

Still, there are more libertarian theories of justice that do not require universal coverage at all, regardless of scaling. Thus, although there is a broad normative mandate for SCS, its appeal may not be universal.⁹¹ Yet whatever reasons require health insurance coverage would presumptively require SCS too. After all, cost-sharing is just the absence of insurance for certain costs.

As an alternative approach to this issue, the language of taxation may provide normative traction as to the fair distribution of healthcare expenses between individuals and their collective insurance pools. A “progressive” tax is typically paid as a percent of adjusted income, with several tiers of increasingly higher percentages.⁹² Such a policy is sensible to the extent that income past a certain level is more disposable than income at the lower levels, which must be allocated to basic human needs.⁹³ A “flat rate” or “proportional” tax, is one where everyone pays the same percentage of income. Although rare today in overt forms, a “per-head” tax is one where each individual pays the same dollar-amount, regardless of wealth or income.⁹⁴ The per-head tax is thought to be objectionably regressive.

Our current system, in which each employee faces the same amount of healthcare costs in order to get the full insurance of Zone 3, is analogous to a head tax.⁹⁵ It is regressive in the sense that lower-paid workers must pay a larger percentage of their incomes than higher-paid workers.

I am here invoking the familiar progressivity of the income tax as a way to

insurance’ if she does not have ‘catastrophic coverage’ for unexpected, large, medically necessary care,” and if that coverage means anything, it must protect people against declaring bankruptcy or losing their house on account of the medical bills).

91. See Uwe Reinhardt, *Uncompensated Hospital Care*, in UNCOMPENSATED HOSPITAL CARE: RIGHTS AND RESPONSIBILITIES 1, 6 (Frank A. Sloan et al. eds., 1986) (arguing that normative debates about health policy are stymied by a difficulty of settling on first principles).

92. See Leo P. Martinez, “To Lay and Collect Taxes”: *The Constitutional Case for Progressive Taxation*, 18 YALE L. & POL’Y REV. 111, 117 (1999) (surveying the rationales and arguing for constitutionality). See generally Joseph Bankman & Thomas Griffith, *Social Welfare and the Rate Structure: A New Look at Progressive Taxation*, 75 CALIF. L. REV. 1905 (1987) (arguing that the diminishing marginal utility of money makes it efficient to take more from higher-paid individuals).

93. Martinez, *supra* note 92, at 117. Even modern progressivity, which may be taken for granted, is not uncontroversial. See, e.g., Frank Warren Hackett, *The Constitutionality of the Graduated Income Tax Law*, 25 YALE L.J. 427, 438 (1916) (It is “untenable . . . that a man’s ability to pay ought to be taken as a measure of what he should be made to pay.”).

94. Sales taxes on basic goods like food staples can be regressive in this sense, because they tax each person for the fixed cost of being alive, regardless of income. Thus, those with lower incomes must pay a higher proportion of their incomes in the sales tax on the basic goods. For this reason, some jurisdictions exempt basic goods from sales tax. See Susan Pace Hamill, *An Argument for Tax Reform Based on Judeo-Christian Ethics*, 54 ALA. L. REV. 1, 50 (2002).

95. See Clark C. Havighurst & Barak D. Richman, *Distributive Injustices in American Health Care*, 69 L. & CONTEMP. PROBS. 7, 42 (2006) (explaining that the current system is regressive because higher-income members utilize services more than lower-income members).

highlight the contingent nature of our current baseline for cost-sharing, where each person pays the same amount. Against the per-capita baseline, scaling may seem provocative. But if our society had started there, it might seem completely natural, and a per-capita system might seem odd. Similarly, in addition to proportional taxation, it has become routine to use inflation-adjusted incomes to make comparisons across time, and to use purchasing power parity calculations to make comparisons across foreign currencies. The use of nominal equivalence in health insurance is thus something of an outlier.

One might take this invocation of the tax code more literally, and then challenge the applicability of normative theories of taxation to cost-sharing burdens in employer-based health insurance.⁹⁶ Do such “public” conceptions of justice apply in the private sector? However, given the massive tax-subsidy that the United States government provides for employer-sponsored health insurance, it would be difficult to argue that these transactions are so private that they escape the demands of justice.⁹⁷

Putting that predication problem aside, the current cost-sharing mechanism is even worse than a head tax or a flat tax because the ability to make initial cost-sharing payments is sometimes the precondition for accessing subsequent healthcare. Additionally, it has the effect of redistributing from common premiums paid by all to benefits enjoyed by the wealthy.⁹⁸ These are sometimes called “vertical equity” problems.⁹⁹ It is also perverse to charge individuals premiums for health insurance that has deductibles so high that the beneficiary is unlikely to ever actually get covered healthcare.¹⁰⁰ Larger questions about how health insurance interacts with the tax code are revisited below.¹⁰¹ For present purposes it suffices to show that the current per-head user fees for healthcare are regressive in application, and that SCS is a *prima facie* solution to that problem.

More broadly, it is interesting to see how SCS can change the terms of the

96. Americans have traditionally viewed health insurance as a “private” matter, unlike taxes. Descriptively, since World War II at least, this framing has not been accurate, since the federal government has used the tax code to subsidize “private” insurance. Normatively, even aside from this public subsidy, one may cogently argue that such a fundamental determinant of wellbeing should not be conceived as a private concern, immune from the demands of justice.

97. See *infra* Section III.C.

98. Bloche, *supra* note 52, at 1322 (discussing this “Reverse Robin Hood” effect).

99. See e.g., Hoffman, *Oil and Water*, *supra* note 89, at 33 (explaining that without income-subsidies, an insurance mandate could cause the “healthy poor [to] subsidize the sick wealthy, a result many would find troubling”); see also David Pratt, *The Past, Present and Future of Health Care Reform: Can It Happen?*, 40 J. MARSHALL L. REV. 767, 784 (2007).

100. See Paul D. Jacobs & Gary Claxton, *Comparing the Assets of Uninsured Households to Cost Sharing Under High-Deductible Health Plans*, 27 HEALTH AFF. w214 (2008) (arguing that it is a poor use of money to pay insurance premiums to get insurance with a deductible that one is unlikely to be able meet).

101. See *infra* Sections III.C & III.D.

normative debates around health insurance. Consider desert and value as criteria for evaluating cost-sharing burdens in general, with or without income scaling. Along the desert dimension, some have criticized cost-sharing from the perspective of “luck egalitarianism,” the theory that an individual should not bear responsibility for healthcare costs merely because one is unlucky enough to be sick.¹⁰² Such costs are arguably not deserved for persons who have not taken unreasonable health risks. In this vein, John Nyman has asked, “What healthy person would purchase a coronary bypass procedure, a leg amputation, or a liver transplant just because the price has fallen to zero?”¹⁰³ People buy those services because they feel that they need them, and will do so, to the extent that they are able, regardless of price. In this domain, the “behavioral” function of cost-sharing is stymied, and cost-sharing burdens may seem like an inequitable tax on being sick.¹⁰⁴ These risks should arguably be redistributed through insurance instead.

If one had a reliable way to distinguish deserved health costs from undeserved health costs, then such a desert criterion could be implemented in conjunction with SCS. Cost-sharing would be waived for “undeserved” healthcare costs, and the remaining costs would be scaled.

However, SCS may actually obviate the need for such an adjustment. It takes much of the wind out of the “tax on sickness” critique of cost-sharing. The core intuition of the luck egalitarian is expressed as the idea that we are “a country in which no one will ever again suffer financial disaster because they had the bad luck to get sick.”¹⁰⁵ By adjusting cost-sharing burdens in accordance with ability to pay, SCS takes the threat of financial disaster off the table, thereby (imperfectly) ensuring that unbearable risks will not be distributed according to bad luck. Similarly, with SCS the question is no longer whether a patient will

102. See, e.g., RONALD DWORKIN, *SOVEREIGN VIRTUE* 73 (2000) (“Brute luck is a matter of how risks fall out that are not in that sense deliberate gambles.”); Hoffman, *supra* note 1, at 1922–32 (discussing the brute luck conception of health insurance).

103. John A. Nyman, *American Health Policy: Cracks in the Foundation*, 32 J. HEALTH POL. POL’Y & L. 759, 766 (2007); see also Swartz *supra* note 9, at 10 (noting that in situations of intense healthcare, “people have very little control . . . because physicians and other providers follow norms of care”).

104. See *Universal Health Care: Hearing on S. 531 and H. 1947 Before the S. Comm. on Ways & Means*, 1999 Leg., 181st Sess. 10 (Mass. 1999) (statement of Alan Sager & Deborah Socolar, Access & Affordability Monitoring Project); NEWHOUSE & INS. EXPERIMENT GRP., *supra* note 52, at 356 (discussing the concern that for the chronically ill, “[p]aying the initial cost sharing year after year may also be viewed as inequitable—that is, as a tax on the sick”); Jacobi *supra* note 90, at 577 (similar); Peter Vallentyne, *Brute Luck, Option Luck, and Equality of Initial Opportunities*, 112 ETHICS 529, 532–38 (2002) (similar); Daniel Wikler, *Who Should Be Blamed for Being Sick?*, 14 HEALTH EDUC. & BEHAV. 11 (1987) (similar).

105. Hoffman, *supra* note 1, at 1922 (quoting Congressman Steny Hoyer); see also Bloche, *supra* note 52, at 1325 (“Medical coverage is more than a business proposition; it is an expression of our commitment to each other. Cost sharing that renders high-value care unaffordable breaches this commitment.”) (emphasis added).

have access to healthcare. The question is simply whether its bearable costs should be paid individually or collectively.

In this light, while SCS will cause high-income individuals to pay more in absolute terms when they get sick, it is difficult to say that such a burden is unjust. High-income individuals likely also benefitted from luck in other dimensions of life.¹⁰⁶ Unless luck egalitarians are going to undertake a massive multidimensional redistribution scheme, there would seem to be no reason to focus on health in particular. Thus, where the luck egalitarian critique of cost-sharing has the most intuitive force, SCS moots the concern. These considerations suggest that the criterion of “ability to bear risk” should be prioritized over the “deservedness” criterion when designing cost-sharing mechanisms. To the extent that a luck egalitarian objection to cost-sharing remains forceful, SCS has clarified the terms of the debate.

Consider a more profound rejoinder that any proposal to increase cost-sharing, even among the relatively wealthy, is unjust. Rather than putting an affordable price on healthcare as a rationing function, one could cogently argue for other mechanisms: some central planner—a private or public regulator—could simply refuse to allow healthcare spending that seems wasteful at the prices demanded by producers and providers.¹⁰⁷ One difficulty of such an approach is that drugs and devices may be more valuable for some individuals than others because of heterogeneity in biology, social circumstances, and personal preferences. This makes it difficult for a third party to assess value to a particular patient.¹⁰⁸ Another difficulty is that such centralized rationing tends to reduce patient choice. Cost-sharing is unique as a rationing mechanism because it keeps the choice in the hands of the incentivized consumer.¹⁰⁹ For these reasons, low-income and high-income individuals alike may rationally prefer SCS over other rationing mechanisms. Nonetheless, let me emphasize that the argument

106. Luck egalitarians could assert a much more radical thesis that even *bearable* unlucky costs (e.g., the risk of needing an aspirin from the drugstore) should be redistributed through social insurance. For a set of similarly radical claims, nonetheless focusing on expensive treatments, see Shlomi Segall, *Is Health (Really) Special? Health Policy Between Rawlsian and Luck Egalitarian Justice*, 274 J. APPLIED PHIL. 344 (2010) (arguing for public funding of breast reduction surgery, skin color change treatments, gender reassignments, and even surgery to allow male pregnancy, if possible, primarily because they would be unaffordable otherwise).

107. See Christopher Robertson & David Yokum, *The Burden of Deciding for Yourself*, 11 IND. HEALTH L. REV. (forthcoming 2014).

108. See generally Elhauge, *supra* note 63 (discussing the difficulty of rationing according to cost-benefit analyses).

109. See CONSUMER-DRIVEN HEALTH CARE: IMPLICATIONS FOR PROVIDERS, PAYERS, AND POLICYMAKERS, at xvii (Regina Herzlinger ed., 2004) (describing “a radical turn away from the technocratic, top-down policies that just say no to providers and consumers”); John Bronsteen et al., *ERISA, Agency Costs, and the Future of Health Care in the United States*, 76 FORDHAM L. REV. 2297, 2330 (2008) (similar); Robertson *supra* note 76, at 931–43 (explaining the problems with physician rationing and insurer rationing).

here is conditional: if a health insurance system chooses to utilize cost-sharing, then it should be scaled.

Along another dimension of evaluation, some have argued that cost-sharing burdens should be adjusted to reflect the value of the underlying healthcare consumption in order to steer patients towards higher-value healthcare.¹¹⁰ In this move towards “value-based insurance design” (VBID), the highest-value procedures—like vaccinations—would have no cost-sharing burden at all.¹¹¹ This move can address paternalistic concerns that cost-sharing may harm health, even for individuals that can afford those costs. Where such instances can be identified, cost-sharing can and arguably should be waived.

Sometimes VBID may involve scaling upwards as well. For example, insurers have imposed cost-sharing tiers for pharmaceuticals to shift patients towards generic drugs, which have a better cost-benefit profile.¹¹² One problem with this value-based approach is that when costs are scaled upwards, lower-paid beneficiaries may lose access to the more expensive treatments, which are thought to be low-value, and such a change would thereby also undermine equality of opportunity. One might cogently argue that lower-income individuals should not have access to high-cost, low-value healthcare. But if insurance designers have normative commitments to access, equality of opportunity, or patient choice, value-scaling may thus be problematic as applied to lower-income individuals.

Here too, if there is a problem, the solution is to calibrate value-scaling according to the more fundamental criterion of ability to pay, which arises from the very purposes of insurance. The objection to value-scaling can thereby be resolved by SCS when the mechanisms are used together.

While one may be ecumenical about the values that health insurance serves, the foregoing arguments have suggested that ability to pay should be preeminent, as it arises from the very purposes of insurance itself. More broadly, it is clear that there are normative imperatives for reform towards SCS. These normative considerations should inform policy debates and motivate reform in the private

110. See Swartz, *supra* note 9, at 4 (describing this as one of two major “trends in health insurance,” but noting that “to date, the handful of studies on the effects of VBID have been conducted by advocates of VBID”); see also Elhauge, *supra* note 89, at 1480 (arguing that there should be a diversity of health insurance plans, which would allow consumers choice of rationing priorities); Russell B. Korobkin, *Comparative Effectiveness Research as Choice Architecture: The Behavioral Law and Economics Solution to the Health Care Cost Crisis*, 112 MICH. L. REV. 523 (2014).

111. Cf. Patient Protection and Affordable Care Act § 1001(5), 42 U.S.C.A. § 300gg-13 (West 2014) (prohibiting insurers from imposing copays for preventive services). See generally Braithwaite & Rosen, *supra* note 59; Chernew et al., *supra* note 66.

112. See Robinson, *supra* note 9, at 1212 (discussing pharmaceutical tiers and the limits of the technique being applied more broadly).

market for health insurance.

B. Precedents

There are intellectual precedents for SCS. In the market for goods and services, sellers often use differential pricing to sell to consumers with a range of willingness to pay.¹¹³ This strategy can increase access to goods and improve profits for the seller, enhancing overall welfare. Several European countries have adopted income scaling for speeding tickets in an effort to make the deterrent effect proportionate across heterogeneous drivers.¹¹⁴

For health insurance in particular, it is important to distinguish the proposal for scaling cost-sharing (out-of-pocket payments by insured individuals for their medical care) from the scaling of insurance premiums (monthly payments required in order to maintain an active insurance plan). Many scholars have recommended this latter option, which already appears in some federal programs and in benefit plans for about 10% of large employers.¹¹⁵ While premium scaling may serve fairness goals, it does almost nothing on its own to solve the problems of underinsurance and overinsurance.

With respect to scaling of cost-sharing in particular, in the 1970s Martin Feldstein argued for a government-sponsored health insurance system, which would include “an annual direct expense limit (i.e., deductible) that increased with family income,” an idea that he has occasionally revisited with co-

113. See generally ROBERT L. PHILLIPS, *PRICING AND REVENUE OPTIMIZATION* 74 (2005). Variants of this strategy include pure price discrimination, as well as the differentiation of very similar products (e.g., Honda and Acura), so that individual consumers can reveal their own willingness to pay. Coupons are thought to have a similar effect, allowing consumers with greater price sensitivity (and lower opportunity costs for their time) to gain access to consumer products that would otherwise be too expensive.

114. See Frank Jordans, *Speeding Fines Being Linked to Income in Europe*, SFGATE, (Jan. 11, 2010), <http://www.sfgate.com/news/article/Speeding-fines-being-linked-to-income-in-Europe-3275939.php> (reporting a record speeding fine of \$290,000 for a Ferrari driver in Switzerland).

115. See, e.g., Richard L. Kaplan, *Top Ten Myths of Medicare*, 20 ELDER L.J. 1, 25–28 (2012) (explaining that the ACA also created an additional Medicare payroll tax for high-earnings individuals); Richard L. Kaplan, *Taking Medicare Seriously*, 1998 U. ILL. L. REV. 777, 792–94 (1998) (discussing income-based means testing in Medicare); *Employer Health Benefits 2012*, *supra* note 6, at 73 (the 10% figure for employers); Mary E. Medland, *Shaving Health Costs*, HR MAGAZINE, June 2005, at 95–96 (discussing prevalence among employers); Saloner & Daniels, *supra* note 87, at 820 (arguing for “progressive financing” of insurance premiums but noting that “[t]he more payments at the point of service such a system involves, the less progressive it will be (and the ACA includes some such payments)”). The ACA also created refundable tax credits keyed to income to subsidize insurance premium payments for poorer individuals in the exchanges. See Seth J. Chandler, *The Architecture of Contemporary Healthcare Reform and Effective Marginal Tax Rates*, 29 MISS. C. L. REV. 335, 339–40 (2010) (discussing section 1401(a) of the Affordable Care Act).

authors.¹¹⁶ Later that decade, the RAND HIE included a \$1,000 “stop-loss” cap on cost-sharing burdens in all their plans (equal to \$3,846 in 2013), but scaled that cap downwards for lower-income participants.¹¹⁷ While the study has been a cornerstone of health policy research for decades, this particular feature of scaling has received scant attention.¹¹⁸

In the 1980s, a few scholars included income tiers for cost-sharing in comprehensive reform proposals for Medicare.¹¹⁹ In a 1985 survey of employers, Herzlinger and Schwartz found that 7% of firms were scaling deductibles according to income, and they recommended broader adoption of the mechanism.¹²⁰

In the early 1990s, in the only article dedicated to the idea, Rice and Thorpe proposed scaling in the employer-based insurance market, and proposed changes to the tax code to account for other sources of income.¹²¹ Rice and Thorpe also noted that some extant employers (about 2–3%) were then using simple forms of scaling.¹²² Contemporary research has revealed a few such examples.¹²³

116. Martin S. Feldstein, *A New Approach to National Health Insurance*, 23 PUB. INT. 93, 99 (1971); see also DAVID DRAKE, MANDATE FOR 21ST CENTURY AMERICA: UNIVERSAL HEALTH INSURANCE 68 (2007) (attributing the idea to Feldstein and developing it further); Martin Feldstein & Jonathan Gruber, *A Major Risk Approach to Health Insurance Reform*, in 9 TAX POLICY AND THE ECONOMY 103, 103–04 (James M. Poterba ed., 2005) (calculating welfare effects of the proposal, arguing that it could “reduce aggregate health spending by nearly 20 percent”); Martin S. Feldstein, *The High Cost of Hospitals and What to Do About It*, 48 PUB. INT. 40 (1977) (similar).

117. The scaling was based on 5, 10, or 15% of annual income (depending on experimental condition). See NEWHOUSE & INS. EXPERIMENT GRP., *supra* note 52, at 6, 401–02. The experiment was conducted between 1971 and 1982. Using 1977 as the year for reference, the \$1,000 cap on cost-sharing would be equal to \$3,846 in 2013 dollars. See Robert H. Brook et al., *The Health Insurance Experiment: A Classic RAND Study Speaks to the Current Health Care Reform Debate*, RAND CORP. 2 (2006), http://www.rand.org/content/dam/rand/pubs/research_briefs/2006/RAND_RB9174.pdf (using 1977 as the reference-year); *CPI Inflation Calculator*, BUREAU LAB. STAT., <http://data.bls.gov/cgi-bin/cpicalc.pl?cost1=1000&year1=1977&year2=2013> (showing \$3,844.17 in 2013 value).

118. See, e.g., FRANK A. SLOAN & CHEE-RUEY HSIEH, *HEALTH ECONOMICS* 102 (2012) (discussing the RAND study as pivotal for understanding health economics).

119. See William C. Hsiao & Nancy L. Kelly, *Medicare Benefits: A Reassessment*, 62 MILBANK MEM’L FUND Q. HEALTH & SOC’Y 207, 219 (1984) (“If patients have to share in the cost of medical care, they should do so according to their ability to pay.”); Laurence S. Seidman, *Income-Related Cost Sharing: A Strategy for the Health Sector*, in NATIONAL HEALTH INSURANCE: WHAT NOW, WHAT LATER, WHAT NEVER? (Mark V. Pauly ed., 1980) (proposing scaling to be carried out through federal income tax credits).

120. Regina E. Herzlinger & Jeffrey Schwartz, *How Companies Tackle Health Care Costs: Part I*, HARV. BUS. REV., July–Aug. 1985, at 69, 73; see also HERZLINGER *supra* note 63, at 257–58 (reiterating such a proposal in 1999 as one element of a major healthcare reform proposal); Herzlinger & Schwartz, *supra*, at 79 (“To ensure equity,” catastrophic coverage “should be scaled to income.”).

121. Thomas Rice & Kenneth E. Thorpe, *Income-Related Cost Sharing in Health Insurance*, 12 HEALTH AFF. 21, 23 (1993).

122. *Id.*

Since 2000, a few scholars have mentioned the idea of SCS in a sentence or two as part of a larger analysis.¹²⁴ For instance, in a 2006 working paper Jonathan Gruber argued that “ideally, such income-related cost-sharing limits should be incorporated into health insurance more broadly,” and used a 5% cap on cost-sharing to illustrate that it could provide significantly greater protection for many Americans.¹²⁵

Thus, although the concept of scaling has been recognized periodically, it has not yet achieved the sustained attention and prominence in scholarly and policy debates that it deserves.¹²⁶ There has been no sustained consideration of

123. See e.g., Michelle Andrews, *Employers Consider Cutting Health Insurance Premiums for Lower Paid Workers*, WASH. POST, Dec. 5, 2011, http://www.washingtonpost.com/national/health-science/employers-consider-cutting-health-insurance-premiums-for-lower-paid-workers/2011/11/30/gIQA19GCWO_story.html (describing how Pitney Bowes modified one of its health plans in 2011 so that it “sets the deductible, out-of-pocket maximum and company contribution based on salary. Hourly workers, for example, have a \$1,500 deductible and \$3,000 out-of-pocket maximum, while employees at the director level or higher have a \$2,500 deductible and \$5,000 out-of-pocket maximum.”); *Payers Refine Cost-Sharing Techniques to Target Patient Behavior*, *Treatment Choices*, MANAGED CARE WK., Dec. 8, 2003, at 1 (quoting Arnold Milstein discussing and endorsing a move by Rockwell Automation Inc., which “have now begun for the first time to income tier for maximum out-of-pocket limits”); *2013 Benefits Enrollment Guide*, HARV. HUM. RESOURCES 11, http://www.employment.harvard.edu/benefits/pdf/Benefits_Enrollment_Guide.pdf (describing a program that reimburses all further copayments for individual employees earning less than \$95,000 who spend over \$270 on office visits or \$1,000 on prescription drugs and sets lower thresholds for those earning less than \$70,000).

124. See TIMOTHY STOLTZFUS JOST, *HEALTH CARE AT RISK: A CRITIQUE OF THE CONSUMER-DRIVEN MOVEMENT* 196 (2007) (suggesting a major healthcare reform including “[r]easonable out-of-pocket maximums . . . based on household income”); Bloche, *supra* note 52, at 1316 (arguing for “reducing deductibles and copayments for the less well-off”); Alain C. Enthoven & Victor R. Fuchs, *Employment-Based Health Insurance: Past, Present, And Future*, 25 HEALTH AFF. 1538, 1541 (2006) (“Many people believe that a fairer system would allocate costs more in proportion to income because much of the demand for health care arises from reasons beyond the individual’s control, such as genetic predisposition to heart attack or cancer.”); Havighurst & Richman *supra* note 95, at 45 (“Our concerns . . . would be obviated if employers generally offered their employees separate plans, each designed for a different income group.”); Hoffman *supra* note 1, at 1915 (mentioning the possibility of “tailoring unacceptable out-of-pocket exposure based on individual income or assets”); Swartz *supra* note 9, at 24 (“[I]nsurance . . . could contain a cap on the percentage of income that an individual or family has to pay out-of-pocket for medical care.”); J. Frank Wharam, Dennis Ross-Degnan & Merideth Rosenthal, *The ACA and High-Deductible Insurance—Strategies for Sharpening a Blunt Instrument*, 369 NEJM 1481 (2013) (“[V]ulnerable people should be shifted into low-cost-sharing plans. Larger employers might be best positioned to adopt this approach, by making employees’ premium and deductible obligations proportional to their income. They could do so in a cost-neutral manner by cross-subsidizing low-income workers.”); Wharam et al., *supra* note 53, at 1404 (“[P]olicy makers could use similar means-based mechanisms to limit deductibles for low-income people.”).

125. Gruber, *supra* note 71, at 12.

126. See, e.g., Katherine Baicker & Dana Goldman, *Patient Cost-Sharing and Healthcare Spending Growth*, 25 J. ECON. PERSP. 47 (2011) (discussing wealth effects of cost-sharing and reviewing potential reforms to cost-sharing, without discussing income-scaling).

the idea in the legal literature. Indeed, prior to this Article, a leading textbook noted that “nobody [was] proposing a consumer-directed health care plan that would force individuals to pay a large share of extreme medical expenses, such as the costs of chemotherapy, out of pocket.”¹²⁷ This Article does precisely that, for those who can afford to pay such costs. At the same time, the Article proposes to significantly reduce or eliminate cost-sharing for those who are presently underinsured.

There are examples of scaling in public healthcare systems abroad, which often simply waive cost-sharing burdens for poorer beneficiaries rather than scaling proportionally along the full income spectrum.¹²⁸ In the United States, the Medicaid program is likewise income-tested for eligibility (with thresholds varying by state), and within Medicaid there is only nominal or sometimes income-tiered cost-sharing.¹²⁹ Congress has also provided that Medicaid benefits can be used towards Medicare cost-sharing burdens, thus implicitly creating SCS within Medicare for “dual-eligibles” who are enrolled in both programs.¹³⁰ Some state “safety net” programs impose scaled cost-sharing burdens.¹³¹ The drug benefit in Medicare Part D also uses an income and wealth test to limit cost-sharing burdens for the poorest enrollees.¹³² The Veterans Administration waives

127. Paul Krugman & Robin Wells, *The Health Care Crisis and What to Do About It*, N.Y. REV. BOOKS, Mar. 23, 2006, <http://www.nybooks.com/articles/archives/2006/mar/23/the-health-care-crisis-and-what-to-do-about-it/>.

128. See, e.g., Nadeem Esmail, *Health Care Lessons from Japan*, FRASER INST., at iv (Apr. 2013), <http://www.fraserinstitute.org/uploadedFiles/fraser-ca/Content/research-news/research/publications/health-care-lessons-from-japan.pdf> (“All health services in Japan are subject to a uniform 30% co-insurance rate . . . [but t]hose in a state of low income . . . receive subsidies for cost sharing or are exempted.”); Alessandra Lo Scalzo et al., *Italy: Health System Review*, 11 HEALTH SYS. IN TRANSITION 1, no. 6, 2009, at i, xxi (describing how in Italy, “[c]ost-sharing exemptions exist for various groups, including . . . people over 65 years of age with gross household income less than €36 152 per annum”); Philipa Mladovsky et al., *Health Policy Responses to the Financial Crisis in Europe*, WHO 17, 39 (Policy Summary No. 5, 2012), http://www.euro.who.int/__data/assets/pdf_file/0009/170865/e96643.pdf (discussing Austria’s cap on prescription fees for low-income individuals).

129. See *Cost Sharing Out of Pocket Costs*, MEDICAID.GOV, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Cost-Sharing/Cost-Sharing-Out-of-Pocket-Costs.html> (last visited Apr. 19, 2014).

130. For an overview of these programs, see *Medicare Savings Programs*, MEDICAID.GOV, <http://www.medicare.gov/your-medicare-costs/help-paying-costs/medicare-savings-program/medicare-savings-programs.html> (last visited Sept. 13, 2013). Similarly, some states pay deductibles for qualified (low-income) Medicare beneficiaries. See 42 U.S.C. § 1396a(a)(10)(E) (2006); *New York City Health & Hosp. Corp. v. Perales*, 954 F.2d 854, 859 (2d Cir. 1992) (discussing that provision).

131. See, e.g., Mark Hall, *The Costs and Adequacy of Safety Net Access for the Uninsured*, ROBERT WOOD JOHNSON FOUND. 4 (June 2010), <http://www.rwjf.org/content/dam/farm/reports/reports/2010/rwjf61566> (showing required copayments for hospital inpatient care ranging from \$22 at 40% of the federal poverty level to \$945 at 250% of the federal poverty level).

132. See Mark V. Pauly, *Means-Testing in Medicare*, 33 HEALTH AFF. 546, 547 (2004) (“For

copays for the poorest beneficiaries.¹³³

Today, the Affordable Care Act's health insurance exchanges include caps on cost-sharing burdens for individuals who buy insurance therein. These caps reduce OOP liability by two thirds, one half, or one third for poorer individuals.¹³⁴ The ACA further requires that the actuarial value of plans be increased for poorer individuals, so that the insurer bears more of the risk than they otherwise would.¹³⁵

The income scaling for cost-sharing in the current federal programs only operates on the lower end of the income spectrum, enhancing the risk protection goal for those well below median income (and even in that direction, it is questionable whether these reforms go far enough).¹³⁶ These policies do not apply to employers in the large group market where most non-elderly Americans are insured, the focus of this Article.¹³⁷ Nonetheless, these precedents of income scaling being widely used in government programs, along with the evidence of it being implemented by some extant employers, provide evidence that SCS is feasible.

those with incomes below 135 percent of the federal poverty level and with low wealth . . . cost sharing would be limited to no more than \$5 per prescription. The subsidy and the reduced cost sharing adjust on a sliding scale, phasing out at an upper limit of 150 percent of poverty.”).

133. See 38 C.F.R. § 17.110(c)(3) (2013); *id.* § 17.108(d)(10) (incorporating 38 U.S.C. § 1722 (2006)).

134. 42 U.S.C.A. § 18071(c)(1)(A) (West 2014); see generally Chandler, *supra* note 115, at 345–46 (discussing these provisions).

135. 42 U.S.C.A. § 18071(c)(1)(C)(2) (West 2014).

136. Saloner & Daniels, *supra* note 87, at 822 (“[E]ven with the protections from the exchanges, such families would be spending a large portion of their limited income on medical spending . . .”).

137. See *supra* note 2 and accompanying text; see also David Gamage, *Perverse Incentives Arising from the Tax Provisions of Healthcare Reform: Why Further Reforms are Needed to Prevent Avoidable Costs to Low- and Moderate-Income Workers*, 65 TAX L. REV. 669, 672 (2012) (describing “the mismatch that the ACA will create between the tax subsidies available for employer sponsored health insurance and those available for the health insurance purchased by individuals. . . . [T]he ACA maintains . . . tax benefits for employer-sponsored health insurance (which primarily benefit higher-income taxpayers), whereas the new tax subsidies that the ACA will create for health insurance purchased by individuals will primarily benefit lower-income taxpayers.”).

TABLE 1: THE ASYMMETRIC IMPACT OF SCALING OUT-OF-POCKET (OOP) MAXIMUMS ON TOTAL HEALTH SPENDING THRESHOLDS FOR FULL INSURANCE (ZONE 3) BASED ON 6% OF HOUSEHOLD MEAN INCOME FOR EACH INCOME QUINTILE¹³⁸

Quintile Mean Income	Current OOP Cap	SCS OOP Cap	Change in OOP Cap	Current Zone 3 Threshold	SCS Zone 3 Threshold	Change in Zone 3 Thresholds
\$11,000	\$3,000	\$1,000	-\$2,000	\$12,000	\$1,000	-\$11,000
\$30,000	\$3,000	\$2,000	-\$1,000	\$12,000	\$7,000	-\$5,000
\$51,000	\$3,000	\$3,000	\$0	\$12,000	\$12,000	\$0
\$82,000	\$3,000	\$5,000	+\$2,000	\$12,000	\$23,000	+\$11,000
\$182,000	\$3,000	\$11,000	+\$8,000	\$12,000	\$57,000	+\$45,000
Averages	\$3,000	\$4,400	+\$1,400	\$12,000	\$20,000	+\$8,000

C. Rationality for Employers

This Part considers whether SCS might be a rational way for profit-seeking employers to provide health insurance. Some have argued that corporate managers are sometimes permitted to “sacrifice corporate profits” when it is in the public interest.¹³⁹ Arguably, no such sacrifice is necessary for employers to adopt scaling of cost-sharing, as SCS is likely to reduce overall insurance outlays (and thus reduce premiums paid by employers) even if it does not change consumption behavior. SCS may also change employee consumption behavior in ways that reduce costs to the insurer and the employer, though there are empirical questions about that effect. SCS may additionally improve worker productivity and the perceived value of the health insurance benefit to workers.

To illustrate these effects, this Part specifies a particular way in which SCS could be implemented. For the sake of simplicity, it assumes that an employer offers only one health insurance plan, but wishes to implement scaling therein.

In principle, all three of the cost-sharing zones could be scaled.¹⁴⁰ At the threshold between Zones 1 and 2 (no insurance and some insurance), annual deductibles could be multiplied by a wage ratio so that higher-paid individuals remain in the no-insurance zone longer than poorer individuals. In Zone 2, the amounts of copays and coinsurance could likewise be scaled so that a poorer individual would pay \$50 or 10% for a doctor’s visit, while a higher-paid

138. Quintile means from DeNavas-Walt et al., *supra* note 39. Zone 3 threshold assumes \$1,000 deductible that counts towards OOP cap, and 18% copay, as in notes 36–37, *supra*. All figures rounded to nearest \$1,000 before calculations.

139. Einer Elhauge, *Sacrificing Corporate Profits in the Public Interest*, 80 N.Y.U. L. REV. 733, 743–47 (2005) (arguing that corporate managers have some bounded discretion to “sacrifice corporate profits” to advance public interest concerns that have a nexus to corporate operations).

140. See *supra* Section I.A for the definition of zones.

individual would pay \$100 or 20%.¹⁴¹ Scaling could also be implemented at the Zone 3 threshold (the cap on annual OOP spending) so that poorer individuals enter full insurance at a lower level of spending than higher-paid individuals.

Suppose that an employer simply chose to scale the Zone 3 threshold, and did so on a simple proportion of income. If the employer believed that its current median level of cost-sharing (say \$3,000 or 6% of income for the median worker) was appropriate for those workers, it could use that point as a fulcrum for scaling. And, for simplicity of illustration, suppose that rather than calculating each worker's OOP maximum individually, the employer used tiers by assigning the cost-sharing level based on the mean income of each quintile and rounding to the nearest thousand. This is a conservative assumption.¹⁴²

Scaling the Zone 3 threshold is the simplest and most compelling way to communicate the concept of scaled cost-sharing because it represents the maximum uninsured risk that an individual faces, which obviously should be related to her ability to bear that risk. Scaling this threshold is impactful for two reasons. First, small changes in the Zone 3 threshold can have a big impact on whether an individual has any price sensitivity when making major consumption decisions, since cost-sharing burdens are typically only a small portion (e.g., 18%) of total healthcare costs. Recall the well-paid individual that faces a \$3,000 OOP maximum and pays an 18% copay, and thus receives full insurance at the point of \$12,111 in total healthcare spending.¹⁴³ Adding another \$1,000 to the Zone 3 threshold would keep the patient engaged with a price signal for an additional \$5,556 of health spending that year (the inverse of 18% multiplied by \$1000).

Many firms have a skewed distribution of wages, highly concentrated in their top employees,¹⁴⁴ not unlike the distribution in the American population at large, shown in Figure 1. A proportional SCS profile (such as 6% of income) will therefore tend to increase cost-sharing obligations and reduce insurance costs on net. As shown in Table 1, for the person earning \$82,000 in the middle of the next income quintile above the median, the 6% SCS would move her \$3,000

141. Although more complicated, such a move would likely be feasible, given that healthcare providers must already check the card or computer system to determine what amount to charge at the point of service.

142. Because the incomes in each quintile are asymmetrically distributed, a policy of individual-tailoring, rather than the example of quintile-tiers, would have even greater effect.

143. See *supra* notes 33–37 and accompanying text for the discussion of “Ms. Median.”

144. See HARRY J. HOLZER, *WHERE ARE ALL THE GOOD JOBS GOING?*, 50 fig.2-9 (2011) (showing that in the middle quintile of firms, the average salary paid to workers at the 90th percentile was about five times that paid to workers in the 10th percentile). Also, across firms, “low-wage firms tend to pay a smaller percentage of premium costs and to offer policies with fewer benefits,” which likely includes higher cost-sharing burdens. Nancy S. Jecker, *Can an Employer-Based Health Insurance System Be Just?*, 18 J. HEALTH POL. POL’Y & L. 657, 660 (1993).

OOP maximum to \$5,000, a difference of \$2,000 more. The person earning in the middle of the quintile below the median gets a \$1,000 reduction in cost-sharing. Comparing these two quintiles, we see that SCS creates twice as much new cost-sharing exposure as it eliminates. Similarly, the comparison between the lowest and highest quintiles shows that SCS creates four times as much cost-sharing exposure as it eliminates.

The effect on Zone 3 (full insurance) thresholds is even more dramatic. The average Zone 3 threshold experienced by workers across all quintiles goes up to about \$20,000 (an increase of 66%) with SCS, due to the skew in wages. This makes SCS quite consonant with broader economic trends towards consumer-directed healthcare and increasing cost-sharing trends over time.¹⁴⁵ SCS provides a better way to do what employers are inclined to do anyway.

Even aside from any impact on consumption behavior, this change will dramatically reduce the amount of health spending that is imposed on the insurer, as more of it will instead be borne by the highly paid workers out-of-pocket. Thus, as the insurer is bearing less of the risk, insurance premiums should be reduced on net. This reform creates a bargaining surplus for the shareholders.

A second reason that Zone 3 is impactful is that nearly two thirds of healthcare spending occurs at the high end, concentrated among the 10% of individuals who spend an average of \$22,000 in a year.¹⁴⁶ As a primary textbook in the field explains, “When you think of the problem of health care costs, you shouldn’t envision visits to the family physician to talk about a sore throat; you should think about coronary bypass operations, dialysis, and chemotherapy.”¹⁴⁷ Although lots of health spending is incurred by those who are elderly (in Medicare) or poor (in Medicaid), a similar concentration of spending is also found in private insurance pools, and among both highly paid and low-paid workers.¹⁴⁸ By increasing the Zone 3 threshold from \$12,000 to \$57,000 for the highest quintile of workers (as shown in Table 1), the SCS reform is uniquely able to provide a solution to costly spending in this impactful domain. Reductions in cost-sharing for lower-paid workers will instead impact the domain of health spending that is less consequential. This suggests that SCS may reduce

145. There may also be competition between insurance pools to increase cost-sharing burdens, so that higher-risk individuals opt out of pools with higher burdens into those with lower burdens. See Amy Monahan & Daniel Schwarcz, *Will Employers Undermine Health Care Reform by Dumping Sick Employees?*, 97 VA. L. REV. 125, 164 (2011).

146. See Cohen & Uberoi, *supra* note 77, at 8 fig.5 (showing that in private insurance pools, 63% of costs are incurred by the top 10% of spenders, and that they spend \$21,939 on average); see also Cohen & Yu, *supra* note 8 (providing population-level averages).

147. Krugman & Wells, *supra* note 127, at 1045; see also Feldstein & Gruber, *supra* note 116, at 109 (explaining the impact of their scaling proposal, since it applies in this domain).

148. See Cohen & Uberoi, *supra* note 77, at 8 fig.5 (discussed *supra* in note 146); *id.* at 9 fig.7 (showing similar distributions of highly concentrated spending across income quintiles).

health spending on net, although such behavioral dynamics are ultimately empirical questions that can only be asserted tentatively here.¹⁴⁹

There are also empirical questions about the effects of reducing cost-sharing burdens for lower-paid workers. O'Brien has reviewed "a burgeoning 'health and productivity management' literature [and] argues that the value of health coverage far exceeds its direct costs to employers."¹⁵⁰ Recent empirical research has shown that when cost-sharing burdens are so onerous to lower-paid workers as to reduce access to healthcare, it reduces their productivity. For example, Dizioli and Pinheiro found that a worker with health coverage misses on average 52% fewer workdays than an uninsured worker.¹⁵¹ Other work suggests that underinsured individuals behave as if they were uninsured.¹⁵² Speaking more directly to cost-sharing, Gibson, Fendrick, and Chernew found that for a \$5 increase in copayment for a pain management drug, the employer may lose \$31–\$42 in absence-related costs.¹⁵³ Other recent empirical studies suggest that for poorer and chronically ill beneficiaries, cost-sharing burdens may actually increase aggregate healthcare spending by causing those with chronic illnesses to be hospitalized more often, rather than appropriately managing their illnesses.¹⁵⁴

SCS may incidentally address medical literacy and wherewithal. The consumer-directed healthcare movement has been rightly criticized for depending on laypersons to make very complicated decisions about whether to accept or decline healthcare.¹⁵⁵ As it happens, wages are a good (but imperfect) proxy for education, intelligence,¹⁵⁶ and access to social resources that can support medical decision making. SCS puts more responsibility for making rationing choices on those that may have the best wherewithal to perform that role successfully.

New scientific evidence suggests that financial stress actually impedes

149. Swartz, *supra* note 9, at 10 ("Little is known from recent studies about the impact of increased patient cost-sharing on total spending.").

150. Ellen O'Brien, *Employers' Benefits from Workers' Health Insurance*, 81 MILLBANK Q. 5, 7 (2003) (internal citations omitted).

151. See Allan Dizioli & Roberto B. Pinheiro, *Health Insurance as a Productive Factor* (June 1, 2012), <http://ssrn.com/abstract=2096415>.

152. See *supra* notes 52–59.

153. Teresa B. Gibson, A. Mark Fendrick & Michael E. Chernew, *Cost-Sharing and Productivity* 16 (Nat'l Bureau of Econ. Research, Working Paper No. 18402, 2012).

154. Amitabh Chandra et al., *Patient Cost-Sharing and Hospitalization Offsets in the Elderly*, 100 AM. ECON. REV. 193 (2010). But see Bikaramjit S. Mann et al., *Association Between Drug Insurance Cost Sharing Strategies and Outcomes in Patients with Chronic Diseases: A Systematic Review*, 9 PLOS ONE e89168, at 1 (2014) (reviewing the literature and finding that "the association between patient copayments and medication adherence varied across studies, ranging from no difference to significantly lower adherence, depending on the amount of the copayment.").

155. See, e.g., Bloche, *supra* note 52 (raising such a criticism).

156. See Stephen J. Ceci & Wendy M. Williams, *Schooling, Intelligence, and Income*, 52 AM. PSYCHOLOGIST 1051 (1997) (finding a high correlation between these three variables).

cognitive performance,¹⁵⁷ and may thereby undermine poorer patients' ability to perform the complicated cost-benefit tradeoffs that are necessary to self-ration in a domain characterized by scientific uncertainty and value judgments about risk and reward. Lab experiments with induced financial stress have found substantial effects, akin to the effects of a full night of sleep deprivation, chronic alcoholism, or a 13-point decrease in IQ.¹⁵⁸ Thus, SCS may enhance productivity and the rationality of health spending.

Notwithstanding these suggestions that lower-paid workers may make bad rationing decisions, other strategies exist to reduce health spending by lower-paid employees who end up in Zone 3 after surpassing their reduced cost-sharing limits. In addition to traditional managed care solutions, one possibility is the "split benefit" concept, which aims to disincentivize expensive, low-value care.¹⁵⁹

In sum, SCS is unlikely to harm the profits of employers. Instead, proportional scaling upwards and downwards from the median would actually reduce insurance costs by allocating more risk overall to workers. This may reduce healthcare consumption in the aggregate, while nonetheless delivering greater health value for workers and the firm.

If an employer is particularly averse to the risk that SCS may backfire and actually increase health insurance premiums on net, it could tentatively begin to use SCS by only scaling upwards. Or, an employer could scale in both directions from the median, but rather than using a linear scaling (say 6% of wages), the employer could use an exponential or cubic scaling, or a tiered scaling that approximates one of those scaling methods. Given the diminishing marginal utility of money, an employee earning \$200,000 per year can probably bear much more than 6% of that income in health expenditure risk.¹⁶⁰ A related method would be to exempt an initial amount of wages paid (say \$25,000) and then impose a larger linear scaling thereafter (say 12% of income). That mode may retain a sense of fairness and simplicity, while again allowing a more aggressive upward scaling. Thus, it seems indisputable that SCS can be implemented in a way that reduces aggregate health spending, which in turn serves the interests of shareholders.

157. Anandi Mani et al., *Poverty Impedes Cognitive Function*, 341 SCIENCE 976 (2013).

158. *Id.* at 980.

159. See generally Robertson, *supra* note 76 (proposing that insurers could pay a small portion of the insurance benefit directly to beneficiaries, which would thus create an opportunity cost for consumption of healthcare services; if beneficiaries decline to consume, the insurer saves the remainder of the insurance benefit, which otherwise would have been paid to the provider, as under the status quo).

160. Such a modification of the proposal begins to seem complicated, but the progressive tiers in the tax code provide precedent.

III. THE OBSTACLES AND OPPORTUNITIES FOR REFORM

One may well ask: if SCS is really such a good idea, why aren't rational employers already using it? One potential explanation is that only within the last decade have healthcare providers and insurers been linked by information technology systems that would allow insurers to customize the cost-sharing burdens for each individual patient (or tier of patients), as SCS requires.¹⁶¹ Still, in the 1970s, the RAND Health Insurance Experiment proved the feasibility of scaling, and some firms were using it in the 1980s.¹⁶² So, while SCS is clearly possible, there are four sets of market failures and legal problems: (a) legal proscriptions, business practices, and cognitive limits that make the employer-sponsored market unlike an individual market for health insurance, where individuals would choose their cost-sharing levels; (b) the per capita caps on cost-sharing in the essential coverage provisions of the Affordable Care Act; (c) the agency and collective action problems under a distorting tax code; and (d) an anti-discrimination provision in employee benefits law. Closer analysis reveals that the problems can be solved, and that the anti-discrimination provision actually provides a lever for policymakers to mandate scaling under current law.

A. Difficulties with Individual Choice

If SCS is a more efficient form of insurance, why are employees not simply choosing health insurance plans that provide the appropriate level of cost-sharing? If lower-paid employees selected plans with lower cost-sharing burdens, a firm could approximate SCS across multiple plans. The experience with the minority of employers that have offered high-deductible health plans (HDHPs) alongside normal health plans has been promising in this regard.¹⁶³ The HDHPs have disproportionately tended to attract the higher-paid employees.¹⁶⁴

There are several impediments to achieving the efficient matching of cost-sharing levels to beneficiaries through self-selection. The most fundamental

161. See generally Paul Starr, *Smart Technology, Stunted Policy: Developing Health Information Networks*, 16 HEALTH AFF. 91, 92 (1997) ("While individual enterprises are building information networks, community networks serving public purposes have lagged. An information revolution in health care is the making, but the hope that it will allow consumers and providers to make smarter choices is still far from being realized.").

162. See *supra* text accompanying note 123.

163. As of 2012, about a third (31%) of firms offered HDHPs. *Employer Health Benefits 2012*, *supra* note 6, at 63.

164. See Melinda B. Buntin et al., *Consumer-Directed Health Care: Early Evidence About Effects on Cost and Quality*, 25 HEALTH AFF. w516, w519 (2006) (reviewing the earlier literature and finding that the participants in high-deductible plans "have higher incomes than those in other plans").

problem with any choice-based mechanism for insurance is adverse selection.¹⁶⁵ The evidence already shows that the sickest employees tend to prefer the plans with the lowest cost-sharing burdens.¹⁶⁶ One of the advantages of employer-based insurance is that it operates within a pool of individuals clustered for non-health reasons. An attempt to instead cause each individual to select more or less insurance based on their private information about their own health needs defeats this purpose, “subdivid[ing] the population into discrete risk categories, which may adversely affect the future stability of the insurance plan options.”¹⁶⁷

Second, accordingly, “companies have long stressed that [employer-sponsored insurance] is a group benefit, and even self-insured firms are loathe [sic] to break the grouping bonds by setting employee shares of premiums that are highly tailored to individual workers’ characteristics.”¹⁶⁸ Part of the problem is epistemic. It is very difficult for the insurer to make an individualized assessment of risk and, by extension, actuarial cost.¹⁶⁹ The law reinforces this norm, prohibiting individual risk rating according to each individual’s health.¹⁷⁰ These norms make employer-sponsored health insurance different from car insurance, which is individually rated and allows consumers to choose their own cost-sharing profiles.¹⁷¹ Instead, large group insurance plans are priced

165. See KENNETH S. ABRAHAM, *DISTRIBUTING RISK: INSURANCE, LEGAL THEORY, AND PUBLIC POLICY* 15 (1986).

166. See Buntin et al., *supra* note 164, at w519 (“Those in CDHC also appear to be in somewhat better health.”); James M. Naessens et al., *Effect of Premium, Copayments, and Health Status on the Choice of Health Plans*, 46 MED. CARE 1033 (2008) (finding that co-morbidities were associated with choice of high-premium, low-cost-sharing plans); Wynand P.M.M. Van de Ven & Bernard M.S. Van Praag, *The Demand for Deductibles in Private Health Insurance*, 17 J. ECONOMETRICS 229 (1981) (finding that adverse selection on health was a stronger determinant of plan choice than income).

167. Naessens et al., *supra* note 166, at 1033.

168. Swartz, *supra* note 4, at 113 n.5; see also Havighurst & Richman, *supra* note 95, at 45 (describing the “heroic” assumptions that would be required for employers to adjust wages based on the cost of insuring each individual); O’Brien, *supra* note 150, at 12 (similar).

169. See Daniel Halperin, *Comment by Daniel Halperin, in USING TAXES TO REFORM HEALTH INSURANCE: PITFALLS AND PROMISES* 57, 57 (Henry J. Aaron & Leonard E. Burman eds., 2008) (explaining that the original IRS decision to exempt health insurance from taxable wages was made in part because the IRS “felt that it was difficult to allocate the costs of health insurance to individual employees”).

170. See *infra* Section III.D (discussing anti-discrimination provisions). See in particular 29 U.S.C.A. § 1182(b)(1) (West 2014) (“A group health plan . . . may not require any individual . . . to pay a premium or contribution which is greater than such premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status-related factor . . .”).

171. Even in these domains, achievement of scaling through self-selection may be unlikely. See generally Stephen Brobeck & J. Robert Hunter, *Lower-Income Households and the Auto Insurance Marketplace: Challenges and Opportunities*, CONSUMER FED’N AM. (Jan. 30, 2012), <http://www.consumerfed.org/news/450> (“A variety of sources report that many LMI [low- and middle-income] households typically purchase only the minimum liability coverage with the highest possible deductible.”).

collectively, which is known as “community rating,” and there is little or no individual choice of plans, much less choices that isolate the cost-sharing variable.¹⁷² In one third of firms, the employer pays 100% of the premiums.¹⁷³ On average, employers pay 82% of the premiums on behalf of their workers.¹⁷⁴ This subsidy undermines the incentive for workers to take on as much risk as they can bear. SCS should not depend on unraveling this knot.

Third, in order to encourage highly paid workers to choose higher cost-sharing, firms would have to give them a financial incentive to do so, but this may be difficult.¹⁷⁵ It may be feasible for a firm to give raises to employees who took on more risk, but social norms, legal rules, and collective bargaining agreements may make it infeasible to lower the take-home wages paid to employees who are already below the median.¹⁷⁶ Thus, an incentive-driven, choice-based mechanism might be more costly on net.

Fourth, the behavioral economics literature suggests that choice is no panacea; it may sometimes overwhelm the capacities of decision makers. Prior work has shown that individuals have difficulty estimating the payments they will actually bear under health insurance cost-sharing systems.¹⁷⁷ In one study, “[o]nly 14% of the sample was able to answer correctly 4 multiple choice questions about the four basic components of traditional health insurance design: deductibles, copays, coinsurance and maximum out of pocket costs.”¹⁷⁸ In

172. See Hoffman, *Oil and Water*, *supra* note 89, at 49 (discussing the long history of community rating and the concept of risk pooling). There is also some evidence that higher-paid employees already consume more health care services, which might make individualized pricing backfire for the higher-paid worker. See Havighurst & Richman, *supra* note 95, at 42 & n.103; *Employer Health Benefits 2012*, *supra* note 6, at 60 (“Most firms that offer health benefits offer only one type of health plan (82%) . . . [but] over half (52%) of covered workers are employed in a firm that offers more than one health plan type.”).

173. *Employer Health Benefits 2012*, *supra* note 6, at 88.

174. *Id.* at 72.

175. See Alain C. Enthoven, *The Fortune 500 Model for Health Care: Is Now the Time to Change?*, 27 J. HEALTH POL. POL’Y & L. 37 (2002); Havighurst & Richman, *supra* note 95, at 46–47 (“[I]n the great majority of instances, the employer pays more for those who choose costlier options—rather than . . . making them pay the full additional cost. . . . [T]hose choosing the cheaper package are indirectly bearing some of the costs incurred by those who choose (and get) more costly care.” (footnote omitted)); Herzlinger & Schwartz, *supra* note 120, at 75 (describing PepsiCo’s efforts to reform its subsidy to guide patients away from a high-cost plan).

176. See Richard Thaler, *Mental Accounting and Consumer Choice*, 4 MARKETING SCI. 199 (1985) (losses are viewed as worse than gains); see also *Payers Refine Cost-Sharing Techniques to Target Patient Behavior, Treatment Choices*, *supra* note 123 (discussing a “20/20 ogre test” where a firm that imposes onerous cost-sharing on poorer workers may suffer public relations problems); *infra* text accompanying note 273.

177. M. Susan Marquis, *Consumers’ Knowledge About Their Health Insurance Coverage*, 5 HEALTH CARE FIN. REV. 65 (1983).

178. George Loewenstein et al., *Consumers’ Misunderstanding of Health Insurance*, 32 J. HEALTH ECON. 850, 858 (2013).

another study, only one third of respondents successfully chose the plan that would minimize their total costs.¹⁷⁹ Individuals are also likely optimistic, and thus underestimate their risk of experiencing large costs.¹⁸⁰ Individuals tended to insure against “high-probability low-loss hazards”; they seemed to have a “disinclination to worry about low-probability hazards,” which may nonetheless be catastrophic.¹⁸¹ More particularly, if presented with a full menu of options with varying premium and cost-sharing levels (which tend to be inversely related), poorer employees may focus more on the former, since that is the immediate, definite, and more salient factor.¹⁸² The premium “price is simple to evaluate, while other characteristics such as deductible and coinsurance are harder to evaluate and trade off against each other.”¹⁸³ Here again, SCS should not depend on heroic improvements in cognitive capacity.

These four reasons may explain why a choice-based system for cost-sharing levels has not emerged in the group insurance market. They also explain why insurance designers may rationally prefer to avoid instituting a choice-based system for cost-sharing burdens. Instead, firms may prefer to simply apply SCS to whatever plan employees may otherwise have.

Alternatively, if a choice-based mechanism is employed, insurance designers should consider using default rules or other mechanisms to nudge individuals towards appropriately scaled policies. One possibility would be to have an automatic scaling of cost-sharing according to wages, but allow higher-paid workers to purchase supplemental insurance policies to offset some or all of their increased cost-sharing burdens. Aside from the primary risk-protection goal of insurance, there is admittedly luxury value in being able to consume healthcare without concern for cost.¹⁸⁴ Primary insurers should, nonetheless, require that such policies be purchased directly from them, so that the primary insurer can price into those policy premiums the stimulation in consumption that will likely

179. F. Heiss et al., *Who Failed to Enroll in Medicare Part D, and Why? Early Results*, 25 HEALTH AFF. 344 (2006).

180. See Christine Jolls, *Behavioral Economics Analysis of Redistributive Legal Rules*, 51 VAND. L. REV. 1653, 1659 (1998) (describing this “amazingly robust finding” in social science).

181. Howard Kunreuther & Paul Slovic, *Economics, Psychology, and Protective Behavior*, 68 AM. ECON. REV. 64, 67 (1978).

182. See generally Keith Marzilli Ericson & Amanda Starc, *Heuristics and Heterogeneity in Health Insurance Exchanges: Evidence from the Massachusetts Connector*, 102 AM. ECON. REV. 493, 494 (2012) (observing that “approximately 20 percent of enrollees choose the cheapest plan available to them”).

183. *Id.* at 494. But see Eric J. Johnson et al., *Can Consumers Make Affordable Care Affordable? The Value of Choice Architecture*, 8 PLOS ONE e81521278 (2013) (finding that consumers overweight OOP burdens when choosing plans).

184. Richard Thaler, *Toward a Positive Theory of Consumer Choice*, 1 J. ECON. BEHAV. & ORG. 39, 53 (1980) (comparing insurance purchasing decisions to an all-inclusive resort, like Club Med).

occur.¹⁸⁵ Otherwise, supplemental insurance creates a severe externality problem. For those that are already adequately insured, those supplemental policies should also not benefit from the tax-preference discussed below, since they do not primarily serve the purposes of risk protection.¹⁸⁶

B. Caps on Cost-Sharing in the Affordable Care Act

One potential legal impediment to SCS is that the Affordable Care Act actually limits maximum cost-sharing burdens. The Act provides that, for individual and small group insurance purchased in the exchanges and for employer-based group health plans, an “essential health benefits package” must cover certain sorts of care and “limit cost-sharing for such coverage” in ways further specified by the tax code.¹⁸⁷ The relevant tax code section pertains to “high deductible health plans,” which are allowed to have, at most, an annual maximum of all cost-sharing burdens of \$6,250 for individuals and \$12,500 for families.¹⁸⁸ Unlike many other regulations, these federal requirements will apply even to the self-insured employers, which cover about 60% of American workers.¹⁸⁹

185. Although Medicare has found it politically infeasible to limit supplemental insurance in this way, private insurers could presumably use their contracts to do so. *See* Cabral & Mahoney, *supra* note 70 (documenting the demand stimulation in Medicare supplemental insurance policies). The demand stimulation would depend in part on the form of supplemental insurance. *See* Jay Hancock, *Health Insurance Industry Touts Supplemental Policies to Cover Medical Costs*, WASH. POST, Feb. 5, 2014, http://www.washingtonpost.com/business/economy/health-insurance-industry-markets-supplemental-policies-to-cover-medical-costs/2014/02/05/f57eb606-8d25-11e3-95dd-36ff657a4dae_story.html (showing that some supplemental insurance is sold in the form of indemnities linked to particular diseases; such payments are thus fungible and retain the opportunity cost function of cost-sharing).

186. *See infra* Section III.C.

187. *See* 42 U.S.C.A. § 18022(a)(2) (West 2014). The applicability of the cost-sharing maximums to large employer-sponsored groups has other statutory bases. *See* Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 77 Fed. Reg. 70644, 70644 (proposed Nov. 26, 2012) (to be codified at 45 C.F.R. pts. 147, 155, 156).

188. 26 U.S.C.A. § 223(c)(2) (West 2014); *see* 45 C.F.R. 156.130(a)(i) (2013); *see also* Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 78 Fed. Reg. 12834, 12847 (Feb. 25, 2013) (to be codified at 45 C.F.R. pts. 147, 155, 156) (providing the \$6,250 and \$12,500 amounts as an illustration for 2013).

189. *See* 78 Fed. Reg. at 12837 (providing that the cap on cost-sharing maximums will apply to self-insured plans); Monahan & Schwarcz, *supra* note 145, at 147 (discussing 42 U.S.C. § 300gg-13). Still, these limitations do not apply to “grandfathered” plans, which are employer-based plans that predate March 23, 2010, unless the plans change significantly. *See* Public Health Service Act § 2707(b), 42 U.S.C.A. § 300gg-6(b) (West 2014). It is possible that employers who implemented SCS could risk losing grandfathered status, since this would increase costs to some enrollees (while decreasing costs to others). Stephen J. Mogila & Daniel L. Saperstein, *The U.S. Supreme Court Upholds the Health Care Reform Law: What’s Next for Employer-Sponsored*

It is hard to imagine why the ACA needs to protect those in the top quintile, who earn at least \$182,000 per year, from paying \$6,250 or more in health expenditures. Employers may be tempted to challenge this cap in court, but such a challenge would fail.¹⁹⁰ As Justice Thurgood Marshall once said, “the Constitution does not prohibit legislatures from enacting stupid laws.”¹⁹¹

Still, the executive and legislative branches should be loath to apply the law to reach such a conclusion. Accordingly, a health plan could seek a waiver to allow SCS. Alternatively, regulators could issue interpretive guidelines to create a safe harbor for non-enforcement, as long as the cost-sharing maximums were met for median employees.¹⁹² The statutory text may be helpful in that it refers to the health “plan” as having a cost-sharing maximum, rather than stipulating that the highest individual member must have that maximum.¹⁹³ Such an executive interpretation of this text could allow scaling using the median point as a fulcrum, which would be entitled to deference by the Judiciary.¹⁹⁴

Ultimately, Congress should change this law to explicitly allow cost-sharing with upwards scaling, as long as insurance performs its functions across the income spectrum. If Congress did act, it could replace the per-head cap on cost-sharing with an income-scaled cap. Similarly, the Affordable Care Act already

Group Health Plans?, 40 HOFSTRA L. REV. 859, 871 (2012) (recommending against cost-sharing hikes). Grandfathered employers could argue that SCS resulted in no change on the aggregate, however. Regardless, only “about one quarter of organizations remain grandfathered and, of those, less than half expect to keep their grandfathered status beyond the next two years.” *2013 Employer-Sponsored Health Care: ACA’s Impact – Survey Results*, INT’L FOUND. EMPLOYEE BENEFIT PLANS 3 (2013) [hereinafter “IFEBP”], <http://www.ifebp.org/pdf/research/2103ACAImpactSurvey.pdf>.

190. For a case dealing with a similar sort of statute that has a rational basis for one group (low-paid workers) but not another, see *Doe v. Mich. Dep’t of State Police*, 490 F.3d 491, 501 (6th Cir. 2007) (“Although we believe that the State’s justification sweeps too broadly, especially with reference to the plaintiffs in the present case, we are constrained to conclude that the rationale articulated in the statute itself satisfies the rational-basis standard.”). See also *F.C.C. v. Beach Commc’ns, Inc.* 508 U.S. 307 (1993) (stating the rule).

191. *N.Y. State Bd. of Elec. v. Lopez Torres*, 552 U.S. 196 (2008) (Stevens, J., concurring) (quoting Justice Marshall).

192. See *Newland v. Sebelius*, 881 F. Supp. 2d 1287, 1298 (D. Colo. 2012) (explaining that the Obama administration “has exempted over 190 million health plan participants and beneficiaries from the preventive care coverage mandate” of the Affordable Care Act). Although they raise thorny constitutional and statutory issues (e.g., in the Administrative Procedure Act), such exercises of executive discretion are exceedingly common. See generally David J. Barron & Todd D. Rakoff, *In Defense of Big Waiver*, 113 COLUM. L. REV. 265, 273–74 (2013); Frank J. Thompson & Courtney Burke, *Executive Federalism and Medicaid Demonstration Waivers: Implications for Policy and Democratic Process*, 32 J. HEALTH POL. POL’Y & L. 971 (2007).

193. See 26 U.S.C.A. § 223(c)(2) (West 2014). Furthermore, the cap statute should be read in light of Congress’s decision to also expand the nondiscrimination rule in health insurance, and the argument below that a per-capita cap violates that rule. See *infra* Section III.D.

194. Whether such executive policymaking would be entitled to *Chevron*, or a lower level of deference, is reserved for another day. See *United States v. Mead Corp.*, 533 U.S. 218 (2001) (discussing the applicability of these standards).

imposes a cap on the employee's required contribution to premiums at 9.5% of household income.¹⁹⁵ If, for example, such a national cap on cost-sharing burdens were set at 6% of each worker's wages, it would more accurately approximate individual worker's abilities to pay compared to a policy in which each firm scaled on its own median wage (the running example used herein).

One might also ask whether such a ceiling on cost-sharing should be complemented by a floor as well. As long as employer-sponsored health insurance continues to be tax-favored (as discussed in Section III.B below), such a minimum level of cost-sharing (a maximum of exempted insurance) might be worthwhile, to raise revenues and minimize the distortion that presently exists under the tax code.

Even without executive or congressional reform, it would be possible for employers to implement scaling underneath the ACA's cap. Currently, 32% of health plans cap maximum OOP burdens at less than \$2,000 for individuals, and another 27% cap at between \$2,000 and \$3,000.¹⁹⁶ These firms could double or triple the cost-sharing burdens of their highest-paid workers. Only 2% of plans are already bumping up against the \$6,250 cap.¹⁹⁷ The remaining 98% of those covered by a cap could implement some scaling, and there is even greater opportunity for scaling within family coverage.¹⁹⁸

There is also more potential for scaling the size of the deductible at the threshold between Zone 1 and Zone 2 for the majority of large employers because the ACA happens to have a gap that does not apply there.¹⁹⁹ The ACA also does not regulate the particular cost-sharing modalities in Zone 2, which allows insurers to impose higher copays and coinsurance on higher-paid employees.²⁰⁰

Ultimately, employers enjoy discretion under current law to use SCS. They can do much better than they now do.

C. Tax Distortions, Agency, and Collective Action

Agency and collective action problems might also explain why firms have not yet adopted SCS on their own. Normatively, a firm's managers are supposed to be the "agents" of the stockholders, which suggests that they should favor SCS

195. 26 U.S.C.A. § 36B(c)(2)(C)(i)(II) (West 2014).

196. *Employer Health Benefits 2012*, *supra* note 6, at 127 exhibit 7.31 ("all plans" row).

197. *Id.* (showing that 2% of plans have out-of-pocket maximums of \$6,000 or more).

198. For families, the cap is \$12,500, and the common family plans are not twice as high as the common individual plans. *Id.*

199. Maximums on the deductible "do not apply to self-insured plans or health insurance issuers offering health insurance coverage in the large group market." 77 Fed. Reg. 70646-47 (Nov. 26, 2012).

200. *See supra* text accompanying note 23 (defining the cost-sharing zones).

according to the efficiency analysis in Section II.C.²⁰¹ However, the managers responsible for designing the firm's insurance plan are likely paid more than the median worker. Thus, the managers may have a personal preference for non-scaled insurance.²⁰² Even aside from this agency problem, the managers may simply have greater concern for the cost-sharing burdens faced by the highly compensated workers because they are more valuable to the firm.²⁰³

This dynamic can be seen in the related context of income-scaled premiums. One benefits director has explained that "the hardest part . . . is getting upper management to agree to this system."²⁰⁴ Although she does not explicitly identify an agency problem, she explains that her firm was successful in instituting income-scaled premiums because the upper-management happened to be altruistic: "Luckily we have a management team that believes this is the right thing to do."²⁰⁵ Unlike tiered premiums, SCS may reduce the total cost of insurance by improving productivity and changing consumption behavior. Accordingly, rational shareholders may be indifferent to tiered premiums while demanding SCS.

Employers provide insurance to workers in lieu of additional wages.²⁰⁶ For each worker, the optimal amount of insurance (versus cost-sharing, the lack of insurance) is a function of how painful it would be to face an uninsured loss, compared to the cost of insuring that loss, including the administrative loads and wasteful aspects of insurance. "In effect, where losses do not do that much harm, it is more efficient to avoid paying the insurer for administrative expenses to cover it."²⁰⁷ Accordingly, if highly paid workers could be given an actuarially

201. See generally Lucian A. Bebchuk & Jesse M. Fried, *Executive Compensation as an Agency Problem*, 17 J. ECON. PERSP. 71 (2003).

202. See Rice & Thorpe, *supra* note 121, at 25 ("[F]irms' decisionmakers, who have the highest incomes, would have the most to lose personally from the implementation of such a system."). More generally, scholars have identified a similar bias in "the legal and regulatory environment of U.S. healthcare [which] has been structured according to the perceptions and preferences of these same elites." Havighurst & Richman, *supra* note 124, at 7.

203. See David Hyman & Mark Hall, *Two Cheers for Employment-Based Health Insurance*, 2 YALE J. HEALTH POL'Y L. & ETHICS 23, 27 (2001) ("An employer may care greatly about conditions that affect its most highly valued employees, but show less consideration for conditions that disproportionately affect employees who are fungible, or work in a division slated for sale or closure.").

204. Medland, *supra* note 115, at 96 (quoting a director of benefits for the Biltmore Company).

205. *Id.* ("Introducing tiered premiums can generate considerable resistance. Higher compensated employees sometimes argue that it's inequitable to subsidize lower-paid workers' health costs [A benefits broker] explains: . . . 'They argue that everyone gets the same vacation and sick time, so why should this be different?'").

206. O'Brien, *supra* note 150, at 5 (describing this as the "standard economic theory"). See also *supra* note 2 (listing sources that discuss the employer mandate and show the longstanding practice of employers providing health insurance).

207. Mark V. Pauly, *Optimal Health Insurance*, 25 GENEVA PAPERS ON RISK & INS., 116, 116–

fair increase in wages to compensate for that risk, they should be happy to split with their employers the efficiency gain (a bargaining surplus) that comes with SCS. The problem is that the wage substitution (premium) for insurance is typically not tailored to individual workers, and we have already reviewed four reasons why it would be difficult for employers to begin doing so.²⁰⁸

In addition, for higher-paid workers, the current tax code discourages the otherwise-rational substitution of increased wages for decreased insurance. Federal law allows employers to deduct amounts paid for employer-provided health insurance, and employees are not taxed on the value of the insurance received.²⁰⁹ Because the amounts the employer uses to purchase the insurance are not considered part of “wages,” they are exempt from payroll taxes at both the employer and employee levels.²¹⁰ The tax subsidy “gives employers and employees the joint incentive to choose low-deductible, low-coinsurance health plans over plans that involve more cost sharing.”²¹¹ Because the tax code is progressive, charging higher rates for higher levels of income, the effective subsidy for insurance over wages is more pronounced for higher-paid workers, ironically giving them even more reason to opt for comprehensive insurance coverage rather than healthcare consumption through out-of-pocket spending. This progressivity results in a “scalar distortion,” creating incentives and imposing costs that are contrary to optimal cost-sharing scaling. Meanwhile, the federal government spends about \$247 billion a year in foregone revenues to achieve this inefficiency.²¹²

Over the last few decades, federal law has tried to reduce these distortions by creating various special accounts, which allow some tax-preferred healthcare spending.²¹³ In the 18% of firms that have adopted such policies, well-paid employees could avoid taxation on the bargaining surplus achieved by SCS by putting additional wages in tax-preferred accounts.²¹⁴ These accounts are not

17 (2000) (describing risk aversion in terms of diminishing marginal utility, but not discussing heterogeneity of wealth).

208. See *supra* Section III.A.

209. See 26 U.S.C. §§ 105, 106, 162 (2006) (discussing these provisions); see also Joseph Bankman et al., *Reforming the Tax Preference for Employer Health Insurance*, 26 TAX POL. ECON. 43, 43 (2012).

210. 26 U.S.C. § 3121 (2006). See Bankman, *supra* note 209, at 43.

211. Bankman, *supra* note 207, at 44 (citing 26 U.S.C. § 213); see also Martin S. Feldstein, *The Welfare Loss of Excess Health Insurance*, 81 J. POL. ECON. 251, 255 (1973) (showing that tax subsidies of employer-based insurance create overinsurance).

212. See Bankman, *supra* note 209, at 43 (citing Joint Committee on Taxation).

213. See generally John F. Cogan, R. Glenn Hubbard & Daniel P. Kessler, *Evaluating Effects of Tax Preferences on Health Care Spending and Federal Revenues*, 21 TAX POL. ECON. 65 (2006) (discussing these accounts).

214. *Employer Health Benefits 2012*, *supra* note 6, at 202 (showing 17% of small firms, 76% of large firms, and 18% overall offering flexible spending accounts to their workers).

complete solutions for the tax distortion, however. These special accounts reduce the perceived fungibility, and sometimes the actual fungibility, of the set-aside money, thereby undermining its value as compensation and as an opportunity cost for health spending.²¹⁵

The ACA also imposed an excise tax on expensive insurance plans.²¹⁶ The tax comes into effect in 2018, and about 17% of employers are currently redesigning their health plans to avoid the surcharge.²¹⁷ They would do well to incorporate SCS into their revised benefit plans, since it is likely to reduce overall insurance costs.²¹⁸

Of course, Congress could simply repeal the tax preference for insurance over OOP spending, which would remove the economic distortion and raise revenue.²¹⁹ A narrower solution to facilitate SCS would be for Congress to make tax exemption for employer-sponsored health insurance contingent on a scaled cost-sharing design, thereby incentivizing voluntary reform of plan payment structures. That reform could be revenue-neutral if employers changed their behaviors accordingly. As shown below, there may be a way to achieve this outcome under current law.

Nonetheless, in the short run, adjustments in take-home pay may not offset adjustments to cost-sharing. Thus, in addition to the agency problem involving high-paid workers choosing unscaled health plans for the firm, employers who sought to implement SCS would suffer from a collective action problem. Each company seeks to recruit the most talented managers and technical experts, and no employer wants to be the first one to offer a health insurance plan that exposes the worker to ten times as much risk, as well as exposure to taxable health spending, as the plans offered by competing firms. This story may explain why

215. See *Health Savings Accounts and Other Tax-Favored Health Plans*, IRS (Publication No. 969, 2013), <http://www.irs.gov/pub/irs-pdf/p969.pdf> (describing the 20% tax penalty for withdrawals when not used for qualified medical expenses, and describing how flexible spending account balances cannot be carried over to subsequent years); Laura A. Tollen et al., *Risk Segmentation Related to the Offering of a Consumer-Directed Health Plan: A Case Study of Humana Inc.*, 39 HEALTH SERVS. RES. 1167, 1186 (2004) (describing section 125 flexible spending accounts: “Lack of fungibility may thus have the perverse effect of encouraging greater consumption of services than would otherwise have taken place.”); see also Chelsea Helion & Thomas Gilovich, *Gift Cards and Mental Accounting: Green-Lighting Hedonic Spending*, 27 J. BEHAV. DECISION MAKING (forthcoming 2014) (finding that “when individuals are given money in the form of a gift card—even one that they earned themselves—they . . . were more likely to purchase hedonic items with their gift cards than with [cash].”).

216. 26 U.S.C.A. § 4980I (West 2014).

217. IFEBP, *supra* note 189, at 3.

218. See *supra* Section II.C.

219. Another overt solution would be for Congress to provide progressive, refundable tax credits for OOP spending. See Bankman, *supra* note 209, for such a proposal. That reform would maintain a preference for health spending over other spending, but would make well-paid workers indifferent to health spending OOP versus through insurance.

SCS has not yet been adopted, and may motivate legal intervention in this failing market.

D. The Anti-Discrimination Mandate

According to leading health economists, “US law requires that the same health insurance plan be offered by an employer to all employees irrespective of the amount the employee is paid.”²²⁰ Such a characterization of the law suggests that using the “amount the employee is paid” to scale cost-sharing burdens could be illegal. Other leading commentators have made similar claims about federal law, which insurance designers may interpret to proscribe SCS.²²¹

I posit that these interpretations are incorrect. Of course, well-paid workers are not a suspect class like “race, religion, sex, or national origin,” which receive special protection under the law.²²² Since women and minorities often earn less than white men, one could not even make the argument that SCS indirectly discriminates against them.²²³ Instead, it would favor them incidentally. The ACA also prohibits discrimination based on health status.²²⁴ Although sicker individuals tend to pay more in cost-sharing burdens, this fact has never been understood to make cost-sharing illegal. Regardless, the point is irrelevant to wage scaling in particular.

Discrimination in employment benefits based on compensation is regulated.²²⁵ For health coverage to be non-taxable for self-insured employers,

220. Sloan & Hsieh, *supra* note 118, at 144.

221. See, e.g., Swartz, *supra* note 4, at 84 (“[H]ealth insurance is a product that cannot be purchased in small incremental amounts, and employers cannot set up different combinations of wages and health benefits among different employees. Current laws require that employers who offer a fringe benefit must offer the same benefit to all employees; they cannot distinguish among classes of employees by offering different versions of a benefit to different sets of workers.”); see also Hoffman, *supra* note 1, at 1885 (stating that “employers must offer insurance on the same terms to all employees,” but showing in the footnote that the anti-discrimination rule is limited to health status).

222. *Ariz. Governing Comm. for Tax Deferred Annuity & Deferred Comp. Plans v. Norris*, 463 U.S. 1073, 1080 (1983). For a review of the many overlapping non-discrimination statutes, see Peter M. Panken et al., *Litigating Claims of Discrimination in Employee Benefits*, in *ERISA LITIGATION* 453, 460–69 (ALI-ABA Course of Study Materials: ERISA Litig., 2004). ERISA also incorporates the HIPAA proscription on discriminating based on health status. See 29 U.S.C. § 1182 (2006).

223. See DeNavas-Walt et al., *supra* note 39, at 5 (gender); *id.* at 8 (race).

224. See generally Jessica L. Roberts, “Healthism”: A Critique of the Antidiscrimination Approach to Health Insurance and Health-Care Reform, 2012 U. ILL. L. REV. 1159 (2012).

225. See, e.g., 26 U.S.C.A. § 401(a)(4) (West 2014) (definition of a qualified pension plan, requiring that “benefits provided under the plan do not discriminate in favor of highly compensated employees”). See generally Peter J. Wiedenbeck, *Nondiscrimination in Employee Benefits: False Starts and Future Trends*, 52 TENN. L. REV. 167 (1985) (discussing the history and purposes of these provisions); Joseph Bankman, *Tax Policy and Retirement Income: Are Pension Plan Anti-*

“the benefits provided under the plan do not discriminate in favor of participants who are highly compensated individuals.”²²⁶ The ACA imposed that requirement on non-self-insured health plans as well.²²⁷ If these employers fail to comply, they may be sanctioned with excise taxes, civil monetary penalties (of \$100 per day per worker), and civil actions leading to injunctions and equitable relief.²²⁸ The IRS has not yet issued guidance on how this provision will be applied and has also delayed enforcement.²²⁹

When it does come into effect, will the non-discrimination rule be problematic for SCS? Analytically, cost-sharing is not an employment benefit; it is the absence of insurance, which is the benefit. So the question is whether the discrimination rule would prohibit employers from giving more insurance to lower-paid workers.²³⁰ Even if that were discrimination, SCS would not be “in favor of” the highly compensated employees, since they are getting less insurance. Thus, the anti-discrimination provisions present no impediment to SCS.

Discrimination Provisions Desirable?, 55 U. CHI. L. REV. 790, 828 (1988) (arguing that employer-employee bargaining is likely to reach the optimal distribution between benefits and wages, making this market intervention inadvisable). Note that Congress had passed in 26 U.S.C. § 89 (1988) more specific and concrete specifications as to the nondiscrimination rules in the health insurance context, but then repealed that statute in 1989, leaving the general proscription against discrimination in employee benefits in place, as shown below. See 135 CONG. REC. H8093-01 (1989) (memo of Robert D. Reischauer, director of the CBO), 1989 WL 188292 (“Nondiscrimination in the provision of employer-provided health coverage remains an important policy objective and the significant tax expenditures for employer-provided health coverage is justified only if such coverage does not discriminate in favor of highly compensated employees.”).

226. 26 U.S.C.A. § 105(h)(2)(B) (West 2014).

227. 42 U.S.C.A. § 300gg-16 (West 2014) (incorporating the standard at 26 U.S.C.A. § 105(h)(2)(B)); see Gamage, *supra* note 137, at 698 (discussing these provisions).

228. See I.R.S. Notice 2011-1, 2011-2 I.R.B. 259.

229. See *id.* at 3 (“Because regulatory guidance is essential to the operation of the statutory provisions, the [various federal departments] have determined that compliance with § 2716 should not be required (and thus, sanctions for failure to comply do not apply) until after regulations or other administrative guidance of general applicability has been issued under § 2716.”); Robert Pear, *Rules for Equal Coverage by Employers Remain Elusive Under Health Law*, N.Y. TIMES, Jan. 18, 2014, <http://www.nytimes.com/2014/01/19/us/rules-for-equal-coverage-by-employers-remain-elusive-under-health-law.html> (explaining that no enforcement will be likely until 2015 at the earliest); Linda Panszsyk, *Dump FSA “Use It or Lose It” Rule, Commenters Tell IRS*, ASPEN PUBLISHERS TECHNICAL ANSWERS GRP. (TAG) (Oct. 19, 2012, 10:00 AM), <http://healthcare-legislation.blogspot.com/2012/10/dump-fsa-use-it-or-lose-it-rule.html> (reporting on comments of U.S. Department of Treasury attorney-advisor Kevin Knopf at an ABA meeting, discussing IRS Notice 2011-1).

230. See generally *La Fata v. Raytheon Co.*, 302 F. Supp. 2d 398, 417 (E.D. Pa. 2004), *aff’d*, 147 F. App’x 258 (3d Cir. 2005) (reviewing definitions of “discrimination” under similar employee benefits statutes and caselaw applying the concept). In the context of wage-replacement benefits, scaled benefits are explicitly allowed. See 26 U.S.C.A. § 401(a)(5)(A) (West 2014) (“[B]enefits may bear uniform relationship to compensation . . .”).

More provocatively, could these anti-discrimination provisions actually require SCS? Is it possible that health insurance with unscaled cost-sharing is already illegal as a discriminatory employment benefit? At first blush, this claim seems dubious because the per-capita insurance benefits are nominally equal for each beneficiary, and thus facially non-discriminatory.

Still, at the point of healthcare consumption, a cost-sharing burden imposes a precondition on employees accessing the employment benefit. If the worker wants her employer to pay for 82% of the costs of her surgery as an employment benefit, the worker has to be able to pay the 18% coinsurance rate at the point of consumption. In practical terms, the covered healthcare is the employment benefit, and without paying that access fee, the lower-paid employee does not get the benefit.²³¹ This is to say that when a worker is unable to pay the access fee to get a treatment, she is effectively uninsured for that treatment, unlike the wealthier workers who are able to access the treatment.

The point is not merely analytical. Evidence shows that underinsured individuals behave similarly to those without any insurance at all.²³² The empirical findings that have accumulated over decades bear repeating: “low-income people in poor health are more likely to suffer adverse health outcomes, such as increased rates of emergency department (ED) use, hospitalizations, admission to nursing homes, and death, when increased cost-sharing causes them to reduce their use of health care”²³³

In this way, a health insurance plan that reduces wages for all workers and substitutes a benefit that disproportionately goes to wealthy workers is a “reverse Robin Hood.”²³⁴ As Gregg Bloche explains:

Outpatient diagnostic work-ups, which high cost sharing discourages, often trigger cascades of care (including hospitalization)—and spending that exceeds out-of-pocket maxima. Insurance then picks up the bill—more frequently for those who are able and willing to pay out of pocket for the triggering diagnostic work-up. . . . [T]hose who are less able and willing to pay out of pocket, outside the hospital, receive less of the high-cost care that exceeds annual maxima and is therefore insured in full. These less prosperous policyholders thus tap the insurance pool to a lesser degree. Yet for employment-based coverage, at least, all who subscribe to a given plan pay equally into the pool. The result is a cross-subsidy from the less well-off to the more prosperous via

231. See 26 C.F.R. § 1.105–11 (2013) (“Plan benefits will not satisfy the requirements of this subparagraph unless all the benefits provided for participants who are highly compensated individuals are provided for all other participants.”).

232. See *supra* notes 43–59 and accompanying text (defining and documenting underinsurance).

233. Swartz, *supra* note 9, at 12.

234. See *supra* note 97 and accompanying text (describing the “reverse Robin Hood” effect).

premiums and payouts from high-deductible plans.²³⁵

This is a “systematic inequity” where “health insurance premiums paid on behalf of lower-income members go to subsidize the costly consumption habits of those with higher incomes.”²³⁶

This discrimination is a way to subterfuge supplemental compensation as an employment benefit for highly compensated workers. When the income is hidden as a discriminatory benefit, it can escape taxation. The anti-discrimination rule has always had this purchase of policing abuse of the tax exemption.²³⁷

This argument would arguably be inapplicable to the 10% of firms that already scale the worker’s contribution to health insurance premiums progressively, if that scaling is progressive enough to counterbalance the regressive effects of per-capita burdens at the point of consumption.²³⁸ However, this Article has shown that scaled cost-sharing would be more efficient than premium-scaling, since it may also improve productivity and consumption behavior.²³⁹ More generally, firms might argue that the forgone wages that it uses to purchase health insurance benefits are somehow proportionate to income, such that the higher-paid workers actually “pay” more for the benefit. However, beyond hand-waving and stipulated accounting methods, such an argument would be difficult to demonstrate empirically, since the counterfactual is unknown. Worse, the argument might cut too broadly, undermining any application of the anti-discrimination rule, for healthcare or other employment benefits.

The discrimination argument would also be inapplicable to an insurance plan that has such low cost-sharing burdens that even the poorest workers have no difficulty securing healthcare. The trend over recent years, however, has been to dramatically increase cost-sharing burdens in order to reduce healthcare spending and remain competitive.²⁴⁰ As that trend continues, the anti-discrimination rule can ensure that additional burdens are distributed at least somewhat equitably.

For firms that fail to scale, ERISA provides a private cause of action for

235. Bloche, *supra* note 52, at 1322.

236. Havighurst & Richman, *supra* note 95, at 42. The authors note that “these matters do not appear to have been specifically studied by others.” *Id.* at 43. My own search of the literature has failed to find empirical documentation of this precise effect, specifically disaggregating the insurer’s spending for workers by income.

237. See Bruce Wolk, *Discrimination Rules for Qualified Retirement Plans: Good Intentions Confront Economic Reality*, 70 VA. L. REV. 419, 434 (1984) (“Congress designed the discrimination rules to ensure that retirement plan benefits will flow to lower paid employees.”). See generally PETER WIEDENBECK, *ERISA: PRINCIPLES OF EMPLOYEE BENEFIT LAW* 303–11 (2010).

238. See *supra* note 115 (listing sources that discuss the scaling of premiums).

239. See *supra* Section II.C.

240. See *Employer Health Benefits 2012*, *supra* note 6, at 5 exhibit F (showing a nearly tripling in six years of the proportion of firms with an annual deductible over \$1,000).

workers to police such discrimination.²⁴¹ Thus, litigation could force employers to adopt SCS. However, given the novelty of the theory here asserted, the courts would be more agreeable if the reform were achieved through the prospective use of IRS notice-and-comment rulemaking.²⁴²

A pragmatic purpose for the IRS to intervene in favor of SCS would be to rationalize the larger tax code as amended by the ACA. As shown in Section III.C above, the tax code may be distorting the market, which would otherwise settle on SCS. Further, David Gamage has compellingly argued that the current form of the ACA creates a perverse incentive for poorer workers to opt out of employer-sponsored health insurance (or even out of employment altogether) and to get the income-scaled subsidies through the exchanges instead.²⁴³ If the IRS were to use the antidiscrimination power to implement income scaling in employer-sponsored insurance, those distortions would be muted.

An IRS mandate for SCS would admittedly be a change of course for the IRS, though it would not be without basis in current regulations. In the regulations applying the health insurance non-discrimination provision for non-self-insured plans, the IRS has said that,

Not only must a plan not discriminate on its face in providing benefits in favor of highly compensated individuals, the plan also must not discriminate in favor of such employees in actual operation. The determination of whether plan benefits discriminate in operation in favor of highly compensated individuals is made on the basis of the facts and circumstances of each case.²⁴⁴

That passage seems to suggest that unscaled preconditions for accessing employment benefits discriminate in favor of highly compensated employees in actual operation.

However, the IRS regulation goes on to say that “[a] plan is not considered discriminatory merely because highly compensated individuals participating in the plan utilize a broad range of plan benefits to a greater extent than do other employees participating in the plan.”²⁴⁵ That passage appears to have never been

241. Section 502(a)(3) of ERISA permits a participant, beneficiary, or fiduciary to bring a civil action to enjoin any act or practice that violates ERISA or the terms of the plan, or to obtain “other appropriate equitable relief” due to an ERISA violation. 29 U.S.C. § 1132(a)(3) (2012). *See also* I.R.S. Notice 2010-63, 2010-41 I.R.B. 420 (stating that if an insured group health plan fails to comply with section 2716 of the Public Health Service Act, “the plan is subject to a civil action to compel it to provide nondiscriminatory benefits”).

242. *See* Christensen v. Harris Cnty., 529 U.S. 576, 587 (2000) (distinguishing rules that have the force of law from mere opinion letters or enforcement guidelines).

243. *See* Gamage, *supra* note 137.

244. 26 C.F.R. § 1.105-11(c)(3)(ii) (2013).

245. *Id.*

litigated.²⁴⁶

For other technical aspects of determining whether a health insurance plan is discriminatory, the IRS has pointed towards the non-discrimination provisions in the pension plan context, which have benefited from much more litigation and development.²⁴⁷ There, just as in the health insurance context, the IRS has long said that “[t]he law is concerned not only with the form of a plan but also with its effects in operation.”²⁴⁸

In particular, the IRS imposes a test to ensure that contributions to 401(k)s are proportionate to income for all workers.²⁴⁹ The IRS regulations applying the antidiscrimination provision for the pension statute also warn that discrimination can arise in the way “in which income, expenses, gains, or losses are allocated to accounts under the plan.”²⁵⁰ One commentator has argued that, under this rule, it would be “certainly discriminatory” for a plan to impose an investment management fee to the plan beneficiaries on a per-capita basis.²⁵¹ This insight is equally applicable to the per-capita cost-sharing maximums that are currently used in health insurance. Similarly, in the pension plan context, it has been recognized that an employer’s uniform rule for vesting may have the effect of

246. Research reveals only a single private letter ruling that quoted, but did not analyze, that passage. See I.R.S. Priv. Ltr. Rul. 81-34-129 (May 29, 1981). See also Wiedenbeck, *supra* note 225, at 221 (discussing the theory that “[i]f average utilization by members of the suspect group is greater than for other employees, one may conclude that the plan contravenes the applicable amount nondiscrimination rule”).

247. 26 C.F.R. § 1.105-11(c)(2)(ii) (2013).

248. *Id.* § 1.401-1(b)(3) (2013). See *Lansons, Inc. v. Commissioner*, 69 T.C. 773, 780 (1978), *aff’d*, *Lansons, Inc. v. Commissioner*, 622 F.2d 774 (5th Cir. 1980) (discussing this provision); see also *id.* at 789 (Simpson, J., dissenting) (collecting cases).

249. See *401(k) Plan Fix-It Guide – The Plan Failed the 401(k) ADP and ACP Nondiscrimination Tests*, IRS, <http://www.irs.gov/Retirement-Plans/401%28k%29-Plan-Fix-It-Guide---The-plan-failed-the-401%28k%29-ADP-and-ACP-nondiscrimination-tests>. (last visited Sept. 4, 2013).

250. 26 C.F.R. § 1.401(a)(4)-1 (2013).

251. Berglund, *supra* note 256, at 154 (“[A]llocating the investment management fee on a per capita basis is certainly discriminatory. The larger account balances will generate more investment management fees than the smaller account balances, and highly compensated employees are likely to have the highest account balances. Charging the smaller account balances for a portion of the investment management fees generated by the larger account balances basically improves the return of highly compensated employees’ account balance at the expense of the non-highly compensated employees.”). But see *Field Assistance Bulletin 2003-3: Allocation of Expenses in a Defined Contribution Plan*, DEP’T OF LABOR (May 19, 2003), http://www.dol.gov/ebsa/regs/fab_2003-3.html (suggesting that either a pro rata or per capita allocation may be appropriate, depending on the circumstances, but not discussing the application of the anti-discrimination rule). For an argument raising concerns about the discriminatory impact of per capita plan expense allocation, see Pamela Baker, *Payment of Plan Expenses with Plan Assets: What Can You Do, What You Can’t Do, What You Should Think About*, in *PENSION, PROFIT-SHARING, WELFARE, AND OTHER COMPENSATION PLANS* 757, 776 (ALI-ABA Course of Study Materials: Pension, Profit-sharing, Welfare, and Other Compensation Plans, 1993).

discriminating against lower-paid workers who switch jobs more frequently.²⁵² Accordingly, although there are difficult line-drawing problems, Congress and the IRS have provided a safe harbor to prevent firms from exploiting this background distribution in a way that egregiously discriminated in favor of highly compensated workers.²⁵³

Facial discrimination is neither necessary nor sufficient for the IRS to find discrimination. For example, a distinction between salaried and clerical employees may appear facially discriminatory, but the statute says that discrimination should not be found “merely because” a plan includes that distinction.²⁵⁴ Even there, the IRS has reserved its discretion to find a disparate impact based on precisely those provisions.²⁵⁵ The IRS has preserved an ultimate discretion to examine plans pragmatically based on a finding of discriminatory impact, regardless of the mechanism.²⁵⁶ If the IRS were to determine that unscaled cost-sharing were discriminatory, it would be entitled to substantial deference by the courts.²⁵⁷

Admittedly, it is peculiar to suppose that a form of benefits used openly by employers nationwide for decades could suddenly be found to be a form of illegal discrimination.²⁵⁸ Nevertheless, the statute of limitations presents no impediment because each application of an employer’s discriminatory policy is itself a violation, regardless of when the policy was enacted.²⁵⁹ The Supreme

252. See Wolk, *supra* note 237, at 451.

253. See *id.*

254. See 26 U.S.C. § 401(a)(4)–(5) (2006).

255. 26 C.F.R. § 1.401-1(b)(3) (2013) (“[S]ection 401(a)(5) specifies certain provisions which of themselves are not discriminatory. However, this does not mean that a plan containing these provisions may not be discriminatory in actual operation.”).

256. “What the IRS is basically saying is that, despite all the supposedly objective tests set forth in the rules, there is still an overriding ‘smell’ test which a plan must satisfy before it will be considered non-discriminatory.” Brian W. Berglund, *The Nuts and Bolts of Discrimination Testing*, in *FUNDAMENTALS OF EMPLOYEE BENEFITS LAW* 131, 151 (ALI-ABA Course of Study Materials: Fundamentals of Emp. Benefits Law, 2004).

257. *Loevsky v. Commissioner*, 55 T.C. 1144, 1149 (1971), *aff’d*, 471 F.2d 1178 (3d Cir. 1973) (holding that an IRS determination as to discriminatory effect should not be set aside unless it is found to be unreasonable, arbitrary or an abuse of discretion).

258. See Gamage, *supra* note 137, at 700 (considering and rejecting a similar argument that it would be discriminatory for employers to construct their health insurance plans in a way that encourages lower-paid workers to purchase insurance on the individual exchanges instead). Note that Professor Gamage does not consider the “merely because of” proviso discussed herein.

259. *Lewis v. City of Chicago*, 560 U.S. 205 (2010); see, e.g., *Chin v. Port Auth. of N.Y. & N.J.*, 685 F.3d 135, 158 (2d Cir. 2012) (applying the *Lewis* holding to find that each time the Port Authority failed to promote one of the plaintiffs, that plaintiff had 180 days to challenge the decision); see also *Nat’l R.R. Passenger Corp. v. Morgan*, 536 U.S. 101, 117 (2002) (explaining that if any “act contributing to the [hostile work environment] claim occurs within the [statutorily required] filing period, the entire time period of the hostile environment may be considered by a court for the purposes of determining liability”).

Court has rejected the notion that “if an employer adopts an unlawful practice and no timely charge is brought, it can continue using the practice indefinitely, with impunity, despite ongoing disparate impact.”²⁶⁰

In other contexts, courts have been willing to strike down longstanding practices that were facially neutral, but turned out to have a discriminatory effect in practice. For example, consider the landmark race discrimination case of *Duke Power v. Griggs*.²⁶¹ There, the challenged practice was simply “requiring a high school education or passing of a standardized general intelligence test as a condition of employment,” which the firm had been doing for more than a decade.²⁶² Congress later endorsed the Court’s “disparate impact” theory, codifying it into statute.²⁶³

ERISA scholars do not typically borrow from the racial discrimination case law in this way to shed light on highly compensated individual discrimination, but the analogy is direct. Disparate impact outlaws “employment practices that are facially neutral in their treatment of different groups but that in fact fall more harshly on one group than another and cannot be justified by business necessity.”²⁶⁴ Likewise, this Article has shown that while unscaled cost-sharing burden is facially neutral, in application it has the effect of predicated the employment benefit on the worker’s ability to pay. It thus has a disparate impact.

A similar issue of “vertical equity” arises in litigation over school financing, where it is recognized that a simple funding scheme applied to differently situated children may wreak inequitable results.²⁶⁵ At least four state supreme courts have applied vertical equity concepts in defining their state education clauses.²⁶⁶ In one case, the court held that the needs of students from poor districts required the state to spend more money than it spent on students from wealthy districts in an effort to ensure that the disadvantaged children can “compete in, and contribute to, the society entered by the relatively advantaged children.”²⁶⁷ Just as in the health insurance, equity is measured by equality of

260. *Lewis*, 560 U.S. at 216.

261. 401 U.S. 424 (1971).

262. *Id.* at 425.

263. See 42 U.S.C. § 2000e-2(k) (2006) (enacting the disparate impact theory).

264. *Int’l Bhd. of Teamsters v. United States*, 431 U.S. 324, 335 n.15 (1977), cited with approval in *Hazen Paper Co. v. Biggins*, 507 U.S. 604, 609 (1993); see also *Smith v. City of Jackson*, 544 U.S. 228, 230 (2005) (extending the “disparate impact” theory to the Age Discrimination in Employment Act, after it had previously been limited to racial contexts).

265. See Julie K. Underwood, *School Finance Adequacy as Vertical Equity*, 28 U. MICH. J.L. REFORM 493, 495–96 (1995) (defining the concept).

266. See Preston C. Green, III et al., *Achieving Racial Equal Educational Opportunity Through School Finance Litigation*, 4 STAN. J. C.R. & C.L. 283, 314 (2008).

267. *Abbott v. Burke*, 495 A.2d 376, 390 (N.J. 1985); see Erin E. Buzuvis, “A” for Effort: Evaluating Recent State Education Reform in Response to Judicial Demands for Equity and Adequacy, 86 CORNELL L. REV. 644, 683 (2001).

access.

In both litigation about discriminatory business practices and litigation about tax avoidance schemes, a primary question is whether a provision serves a bona fide business purpose.²⁶⁸ The purpose of health insurance is to guarantee access and protect against unbearable risk, while the purpose of cost-sharing is to reduce wasteful spending on low-value healthcare. A flat cost-sharing scheme simply does not serve these purposes as well as a scaled benefit, since it facilitates wasteful spending at the top and deters high-value spending at the bottom.²⁶⁹ Since scaling could be accomplished at the same or less cost to the employer compared to the current cost-sharing mechanisms (as shown in Section II.C above), per-capita cost-sharing would seem to lack a bona fide purpose. Per capita cost-sharing is discrimination.

Firms could move into compliance by scaling cost-sharing downwards for poorer workers, scaling upwards for wealthier workers, or both.²⁷⁰ The test would turn on whether the benefit effectively provides the same value to highly compensated and other workers.

It is important to note that health insurance benefits are only part of a worker's compensation package, and that the IRS does not regulate inequality in other parts, such as wages. Thus, some firms may attempt to adjust wages at each level to maintain the same net compensation for each worker as they had prior to the reform. Alternatively, the change towards SCS may have no effect on wages. All competing firms in the labor market will be subject to this same mandate, for both highly paid and other workers, which suggests that the market equilibrium may not be disrupted.²⁷¹ There is also a long-standing norm that employer-sponsored health insurance is "community rated," rather than individually priced.²⁷² Additionally, there may be a floor to lower-paid worker wages: "A lot of writing on ERISA suggests that since the nondiscrimination test requires that the low income participate and since the low income will not accept sufficient pay cuts, the highly paid have to allocate part of their tax savings to encourage

268. See, e.g., 42 U.S.C. § 2000e-2(e)(1) (2006) (allowing employers to rebut disparate impact claims by showing that a given provision "is a bona fide occupational qualification reasonably necessary to the normal operation of that particular business or enterprise"); *Coltec Indus., Inc. v. United States*, 454 F.3d 1340, 1350 (Fed. Cir. 2006) (The "anti-abuse provision applies where liabilities are assumed principally for tax avoidance purposes or lack a bona fide business purpose.").

269. See *supra* Section II.C.

270. See Bankman, *supra* note 225, at 830 ("[A]n employer might also meet the requirement of proportionality by reducing the benefits of the highly compensated.").

271. See Halperin, *supra* note 169, at 59 ("If provision of health insurance results in a wage cut by either the pretax cost of health insurance or the cost plus the tax savings, it is not clear whose wages are cut.").

272. See *supra* Section III.A.

the low paid to be part of the plan.”²⁷³ In that case, the net effect of SCS will be to reduce overall income inequality.

Still, it bears emphasis that my interpretation of the non-discrimination rule under current law does not provide a warrant for the IRS to implement an ideally progressive version of SCS. At most, it can correct cases where cost-sharing burdens are so high that they present a barrier to lower-paid workers, undermining the purposes of health insurance. There is no mandate under the tax code for requiring progressive redistribution in employee benefits. Instead, if Congress seeks greater progressivity, it should adjust marginal tax rates, once it appears that insurance is achieving its purposes of securing access and protecting against risk.²⁷⁴

Ultimately, it is clear that current federal law allows SCS. Further, there is a clear basis for holding that the law, and the IRS regulations interpreting that law, actually prohibit unscaled cost-sharing as an impermissible discrimination in favor of highly compensated workers.

CONCLUSIONS

Health insurance can be reformed so it better serves its purposes and accomplishes its normative mandate to protect beneficiaries from unbearable risks and guarantee their access to needed care. By refining the price signal for healthcare, SCS should provide better incentives to consumers, producers, and providers in the healthcare market, making the market more efficient. Scaling will allow patients to make more rational tradeoffs between health spending and other spending, improving the efficiency of the larger economy.

Still, discomfort with cost-sharing, as a market-based solution to the escalation of healthcare costs, will persist.²⁷⁵ Reasonable people can disagree about whether cost-sharing is the optimal way to make healthcare consumption decisions, but if cost-sharing is utilized, it should be scaled according to income.

This Article has suggested that there is a remarkably timely and easy legal mechanism to bring about this change for the 168 million people that get their insurance from their employers. The IRS should use its current authority under

273. Halperin, *supra* note 169, at 59; see also Daniel I. Halperin, *Special Tax Treatment for Employer-Based Retirement Programs: Is It “Still” Viable as a Means of Increasing Retirement Income? Should It Continue?*, 49 TAX L. REV. 1, 14 (1993) (describing this dynamic in greater detail); Wolk, *supra* note 237, at 429–34 (same).

274. See Louis Kaplow & Steven Shavell, *Why the Legal System Is Less Efficient than the Income Tax in Redistributing Income*, 23 J. LEGAL STUD. 667 (1994) (suggesting that redistributive choices should be made overtly in the tax code).

275. See Bruce Vladeck, *The Market v. Regulation: The Case for Regulation*, 59 MILBANK Q. 209, 211 (1981) (“Consumers . . . don’t wish to be forced to make rational trade-offs when they are confronted with medical care consumption decisions. . . . As a society, we may be prepared to pay a substantial economic premium to insulate people from having to make such decisions.”).

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the anti-discrimination provisions of the tax code to eliminate this disparate impact on poorer workers and reduce the distortion caused by the tax preference for insurance over out-of-pocket spending. With little more than the stroke of a pen, the executive branch can eliminate the current distortions that lead to inefficiency and injustice.